

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12001

|  |   |                        |  |  |  |  |  |  |
|--|---|------------------------|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Earl Leon Barnette                              |                        |  |  | 2. Date of Death<br>Month Day Year<br>March 29, 1999   |  | 3. Time of Death<br>6:08 P.M.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Harford Memorial Hospital |                        |  |  | 4b. City, Town, or Location of Death<br>Havre de Grace   |  | 4c. County of Death<br>Harford   |  |
| Funeral<br>Director  | 5. Social Security Number<br>225-30-5420  |                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>72 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>July 9, 1926                                  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Virginia  |                        |  |  |  |  |  |  |
| Usual Residence of Decedent  |   |                        |  |  |  |  |  |  |
| 10a. State<br>MD   |   | 10b. County<br>Harford |  | 10c. City, Town or Location<br>Aberdeen  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br>3919 West Chapel Road  |   |                        |  | 10f. Zip Code<br>21001   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                        | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br>1945-46  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4or 5+) 0  |   |                        |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Civil Service                 |  | 16b. Kind of Business/Industry<br>U.S. Government  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Starling Barnette   |   |                        |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Minnie Jackson  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Estella G. Barnette (Spouse)   |   |                        |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3919 West Chapel Road, Aberdeen, MD 21001 |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Hills Memory Garden  |  | Date<br>4/3/99   |  | 20c. Location - City or Town, State<br>Claypool Hill, VA                             |  |
| 21. Signature of Funeral Service Licensee<br>Kirsten Anylingusbee  |   |                        |  | 22. Name and Address of Facility<br>Tarring-Cargo Funeral Home, P.A.<br>Aberdeen, Maryland 21001-3399                                      |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immadiate Cause (Final disease or condition resulting in death)<br><br>a. Pulmonary Embolism<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                        |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br>Two hours  |   |                        |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>Coronary Artery Disease<br>Myocardial Infarction   |   |                        |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |                        |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |   |                        |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                        | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |                        | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  |   |                        | 28d. Describe how injury occurred  |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                        |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>Bryg MIRZA A. BAIG MD   |   |                        |  | 29c. License number<br>D43115  |  | 29d. Date signed (Month, Day, Year)<br>3-30-99   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>615, S. Union Ave, MD, 21078 (Havre de Grace)  |   |                        |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999   |   |                        | 32. Registrar's Signature<br>B. Sparks   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

99 12002

|   |  |  |  |   |                                |  |  |
|---|--|--|--|---|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ARTHUR CHEWKER BUTTERFIELD</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 21, 1999</b>   |                                | 3. TIME OF DEATH<br><b>1:30 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>185-05-0750</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 29, 1915</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Manor Healthcare Center</b>  |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rising Sun</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Cecil</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |                                | 10b. COUNTY<br><b>Harford</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Forest Hill</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |                                | 10e. STREET AND NUMBER<br><b>1404 Kahoe Road</b>   |  |
| 10f. ZIP CODE<br><b>21050</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>  |                                |  |  |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Accountant</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Food Processing</b>  |                                |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles H. Butterfield</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary C. Smith</b>   |                                |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Alice G. Butterfield</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1404 Kahoe Road, Forest Hill, MD 21050</b>  |                                |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp. 3/22/99</b>   |                                | 20c. LOCATION — City or Town, State<br><b>Towson, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Rd., Abingdon, MD 21009</b>  |                                |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>A.S.C.V.D.</b><br><br>Approximate Interval Between Onset and Death<br><b>10 days</b><br><br><b>years</b> |  |  |  |   |                                |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |                                |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |                                |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |                                |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |                                |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>0-11115</b>   |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-21-99</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Neil Taylor MD, Calvert Manor Healthcare, Rising Sun, MD 21051</b>  |  |  |  |   |                                |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 22 1999</b>   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |                                |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12003

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELSIE (nmn) BANKS

2. Date of Death  
Month Day Year

March 31, 1999

3. Time of Death

4:10 AM

4a. Facility Name (If not institution, give street and number)

Calvert Manor Nursing Home

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

212-28-3624

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 7, 1926 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2109 Nuttall Avenue

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

LeRoy (nmn) Gaunt

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle (nmn) (u/k)

19e. Informant's Name/Relationship (Type, Print)

Lee W. Banks, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1046 Conowingo Road, Conowingo, Maryland 21918

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

4/2/99

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

*John K. McComas*

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

50 West Broadway Street, Bel Air, Maryland 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*BASAL CELL w METASTASIS*

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*John K. McComas*

29c. License number

*152800*

29d. Date signed (Month, Day, Year)

*4/1/99*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*J. Blonzo MD; 314 S. Union Ave, #106, Md. 21074*

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12004

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter James Burford

2. Date of Death

Month Day Year  
MARCH 30, 1999

3. Time of Death

7:30 PM

4e. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

027-01-9730

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 17, 1909

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10e. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

243 Endsleigh Avenue

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1930

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Westinghouse - Defense Contractor

17. Father's Name (First, Middle, Last)

Walter

Burford

18. Mother's Name (First, Middle, Maiden Surname)

Sara

Lamb

19e. Informant's Name/Relationship (Type, Print)

Angela Shaneyfelt/granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

243 Endsleigh Avenue, Baltimore, MD 21220

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

Apr 2 1999

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the immediate cause(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- CONGESTIVE HEART FAILURE (CHF)  
- CHRONIC OBSTRUCTIVE LUNG DISEASE (COPD)  
- DEMENTIA (ALZHEIMERS)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

DS 1245

29d. Date signed (Month, Day, Year)

MARCH 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SADID SHARIF

NORTH ARUNDEL HOSPITAL

301 Hospital Drive, Glen Burnie, MD 21061

State  
Registrar

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

*[Signature]*

Name: Walter Burford  
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12005

|   |   |   |   |                                      |  |   |   |   |  |  |
|---|---|---|---|--------------------------------------|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARY BRENT</b>   |   |   |                                      | 2. Date of Death<br>Month Day Year<br><b>MARCH 29 1999</b>   |   |   |   | 3. Time of Death<br><b>4:45 am</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SPA CREEK CENTER GENESIS ELDER CARE</b>  |   |   |                                      | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>   |   |   |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-56-8201</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 19 1954</b>                   |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |  |
|   | Usual Residence of Decedent   |   |   |                                      |  |   |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>ANNE ARUNDEL</b>  |                                      | 10c. City, Town or Location<br><b>ANNAPOLIS</b>  |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>18 PETERS WAY</b>  |   |   |                                      | 10f. Zip Code<br><b>21401</b>  |   | 10g. Citizen of What Country?<br><b>US</b>                                    |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>1 yr.</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PREVENTIVE MAINTENANCE TECHNICIAN</b> |                                      |  |   | 16b. Kind of Business/Industry<br><b>ANNE ARUNDEL COUNTY BD. OF EDUCATION</b> |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM HARRIED</b>   |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY WATKINS</b>   |   |   |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>DOROTHY HARRIED (SISTER)</b>   |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 101 EDGEWATER, MD. 21037</b>  |   |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   |   |                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHEWS CHURCH CEMETERY</b>   |   | Date<br><b>4/1/99</b>   |   | 20c. Location - City or Town, State<br><b>OWENSVILLE, MD.</b>                                  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Larry G. Reese</i>  |   |   |                                      | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>   |   |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cancer of brain</b>   |   |   |                                      |  |   |   |   |  |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |   |   |                                      |  |   |   |   |  |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |   |                                      |  |   |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |                                      |  |   |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |                                      |  |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |                                      |  |   |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |   |                                      |  |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)                          |   | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                                       |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Gary J. Sprauve</i> |   | 29c. License number<br><b>032026</b> |  | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>                                       |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Gary J. Sprauve 2108 W. Donah Drive Chester, MD 21619</b>  |   |   |   |                                      |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>   |   | 32. Registrar's Signature<br><i>B. Sprauve</i>                  |   |                                      |  |   |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

12006

|  |   |   |   |  |  |  |   |  |  |  |  |
|--|---|---|---|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Irma M. Brashears                               |   |   |  |  |  | 2. Date of Death<br>Month 3 Day 25 Year 99          |  |  | 3. Time of Death<br>2:28 PM                  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Ginger Cove Health Center |   |   |  |  |  | 4b. City, Town, or Location of Death<br>Annapolis   |  |  | 4c. County of Death<br>Anne Arundel          |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-74-4083  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>99 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 4, 1899 |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |  |
|  | Usual Residence of Decedent   |   |   |  |  |  |   |  |  |  |  |
| 10a. State<br>Maryland   |   | 10b. County<br>Anne Arundel   |   | 10c. City, Town or Location<br>Annapolis   |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br>972 Riversedge Circle  |   |   |   | 10f. Zip Code<br>21401   |  |  | 10g. Citizen of What Country?<br>USA                |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |  |  | 16b. Kind of Business/Industry<br>Home              |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Robert Wilson Carr  |   |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Addie Lou Cox   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>F. Arita Dove/ Daughter  |   |   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>972 Riversedge Circle Annapolis, Maryland 21401 |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mayo U.M. Church Cemetery   |  |  | 20c. Location - City or Town, State<br>3-28-99 Mayo, Maryland  |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |   |  |  | 22. Name and Address of Facility<br>George P. Kalas Funeral Home<br>2973 Solomons Island Rd. Edgewater, MD 21037                                 |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |  |  |   |  |  | Approximate Interval Between Onset and Death |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Pneumonia</u><br>Due to (or as a consequence of):   |   |   |   |  |  |  |   |  |  | 1 wk   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. <u>Parkinson's</u><br>Due to (or as a consequence of):  |   |   |   |  |  |  |   |  |  | yrs  |  |
| c.<br>Due to (or as a consequence of):   |   |   |   |  |  |  |   |  |  |  |  |
| d.<br>Due to (or as a consequence of):   |   |   |   |  |  |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |   |   |   |  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  |   |   |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how Injury occurred  |  |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>   |   |  |  | 29c. License number<br>D30718  |   | 29d. Date signed (Month, Day, Year)<br>3-26-99   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>John Saetcrum, 2003 Medical Plaza #100, Annapolis, MD 21401  |   |   |   |  |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 29 1999   |   | 32. Registrar's Signature<br>   |   |  |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

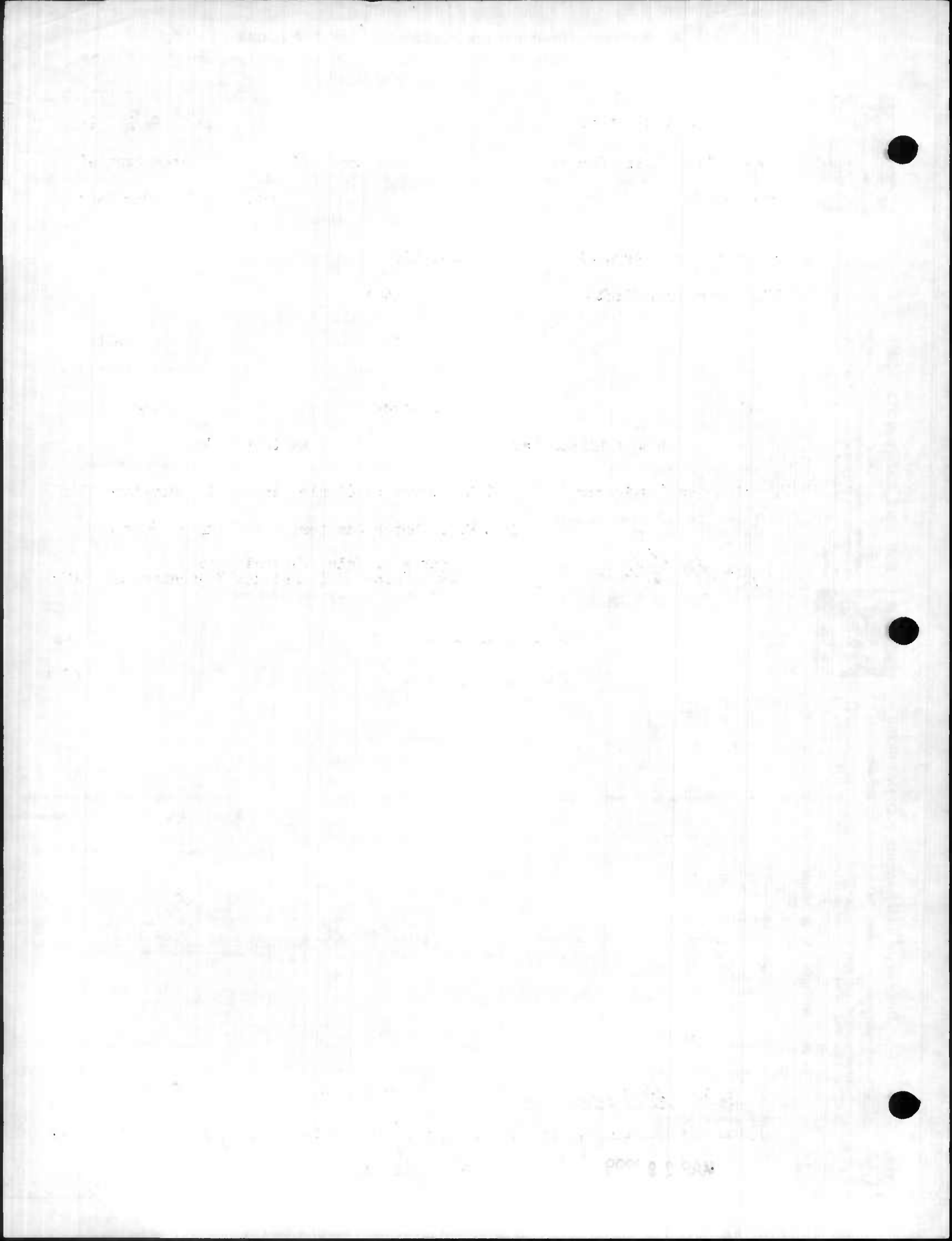
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NATHAN BOORDA

2. Date of Death

March 23, 1999

3. Time of Death

6:33 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital &amp; Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

309-14-0587

6. Sex

M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC 7, 1914

9. Birthplace (State or Foreign Country)

INDIANA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

LA VALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

715 NATIONAL HWY

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

GOVERNMENTAL

17. Father's Name (First, Middle, Last)

SAMUEL BOORDA

18. Mother's Name (First, Middle, Maiden Surname)

GITEL BRUNSWAG

19a. Informant's Name/Relationship (Type, Print)

HELEN M. BOORDA/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

715 NATIONAL HWY, LA VALE, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

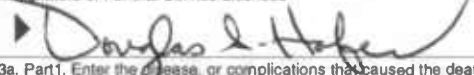
MARCH 24, 1999  
REST LAWN MEMORIAL GARDEN

Date

20c. Location - City or Town, State

LA VALE, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HAFAER CHAPEL OF THE HILLS MORTUARY  
1302 NATIONAL HWY, LA VALE, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BILATERAL PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 WEEKS

11 YEARS

b. CHRONIC LYMPHOCYTIC LEUKEMIA

Due to (or as a consequence of):

1988

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 23371

29d. Date signed (Month, Day, Year)

March 25, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Qamar Zaman, M.D., Johnson Heights Medical Building, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

MAR 26 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitNathan Boorda  
309-14-0587  
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12008

|  |   |  |  |  |   |  |  |  |
|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Ernest Brodie   |  |  |  | 2. Date of Death<br>Month 03- Day 21- Year 99   |  | 3. Time of Death<br>1:55 AM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Frostburg Village Nursing Home  |  |  |  | 4b. City, Town, or Location of Death<br>Frostburg   |  | 4c. County of Death<br>Allegany  |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-07-1397  |  | 8. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>86 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>February 17 1913                              |  |
|  | 9. Birthplace (State or Foreign Country)<br>MD  |  | 10a. State<br>MD   |  | 10b. County<br>Allegany   |  | 10c. City, Town or Location<br>Frostburg   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>1 Kaylor Circle  |  | 10f. Zip Code<br>21532  |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII US Army |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Labor   |  | 16b. Kind of Business/Industry<br>Road  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Andrew Brodie  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Christina McKinnon   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Shirley Fresh daughter  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>228 Braddock Road, Frostburg, MD 21532   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Oak Hill Cemetery  |  | 20c. Location - City or Town, State<br>Lonaconing, MD   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>James E. McKenzie  |  | 22. Name and Address of Facility<br>Eichhorn-McKenzie Funeral Home P.A.<br>Lonaconing, MD  |  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. CONGESTIVE HEART FAILURE<br>Due to (or as a consequence of):<br>f.<br>Due to (or as a consequence of):<br>g.<br>Due to (or as a consequence of):<br>h.<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |   |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |  |   |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>CORONARY ARTERY DISEASE  |  |  |  |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |   |  |  |  |
|  | 29b. Signature and title of certifier<br>Cheryl Nye   |  |  |  | 29c. License number<br>D24951   |  | 29d. Date signed (Month, Day, Year)<br>MARCH 22, 99                                  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>CHANG H. CH. NO. 48 TARN TERRACE, FROSTBURG, MD. 21532  |  |  |  |   |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>MAR 24 1999  |  |  |  | 32. Registrar's Signature   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

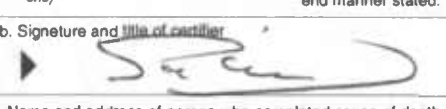
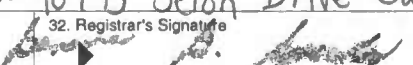
Certificate of Death

Reg. No.

99 12009

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>BETTY JUNE BEACHY</b>  |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>22</b> Year <b>1999</b>  |                                | 3. Time of Death<br><b>04:10 AM</b>  |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |                                | 4c. County of Death<br><b>ALLEGANY</b>   |  |
| 5. Social Security Number<br><b>215 20 6989</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 18, 1925</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  |  |                                |  |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ALLEGANY</b>  |  | 10c. City, Town or Location<br><b>LaVALE</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>800 VALLEY VIEW DRIVE</b>  |  |   |  | 10f. Zip Code<br><b>21502</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SECRETARY</b>  |                                | 16b. Kind of Business/Industry<br><b>KELLY SPRINGFIELD TIRE</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>HORACE WEIMER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES RANKIN</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>EDISON BEACHY / HUSBAND</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>800 VALLEY VIEW DRIVE, LaVALE, MD 21502</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FROSTBURG MEMORIAL PARK</b>  |  | Date<br><b>3/26/99</b>   |                                | 20c. Location - City or Town, State<br><b>FROSTBURG, MD 21532</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>SOWERS FUNERAL HOME, P.A.<br/>60 W. MAIN ST., FROSTBURG, MD 21532</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pancreatic Carcinoma</b><br>Due to (or as a consequence of):<br><br><b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br><b>Unknown</b><br><br><b>Unknown</b> |  |   |  | Approximate Interval Between Onset and Death<br><br><b>Unknown</b><br><br><b>Unknown</b>   |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner   |  | 29b. Signature and Title of certifier<br>  |  |  |                                |  |  |
|   |  | 29c. License number<br><b>DO 40693</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 23, 1999</b>   |                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Samir A. Elwan M.D. 909-B Seton Drive Cumberland MD 21502</b>  |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 23 1999</b>   |  | 32. Registrar's Signature<br>  |  |  |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12010

|  |  |                                |   |   |  |  |   |  |   |   |  |
|--|--|--------------------------------|---|---|--|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Irving Bowers Owens</b>                                       |                                |   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>March 27, 1999</b>                                 |  | 3. Time of Death<br><b>6:15 AM</b>                          |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Salisbury Center: Genesis ElderCare</b> |                                |   |   |  |  | 4b. City, Town, or Location of Death<br><b>Salisbury, MD</b>                                |  | 4c. County of Death<br><b>Wicomico</b>                      |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-20-7702</b>  |                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 10, 1913</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |  |
|  | Usual Residence of Decedent  |                                |   |   |  |  |   |  |   |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Wicomico</b> |   | 10c. City, Town or Location<br><b>Salisbury</b>   |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |
| 10e. Street and Number<br><b>505 South Pine Hurst Ave</b>  |  |                                |   | 10f. Zip Code<br><b>21801</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>2</b>  |  |                                |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrician</b> |  |  | 16b. Kind of Business/Industry<br><b>Electronics</b>  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Irving Thayer Owens</b>  |  |                                |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sadie Bennett</b>  |   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Alda Mae Owens/Daughter</b>   |  |                                |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>607 Edgewater Dr., Salisbury, MD 21804</b> |   |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify): <b>Entombment</b>   |  |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wicomico Memorial Park</b>   |   |  | 20c. Date<br><b>3/29/99</b>  |   | 20d. Location - City or Town, State<br><b>Salisbury, MD</b>  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |                                |   |   |  | 22. Name and Address of Facility<br><b>Holloway Funeral Home Professional Association<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>           |   |  |   |   |  |
| 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Medically Resistant Staph pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |  |                                |   |   |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>4 Days</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Stroke</b><br><b>Renal Failure</b><br><b>COPD</b>   |  |                                |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |                                | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |  |                                | 29b. Signature and Title of certifier<br><i>[Signature]</i>   |   |  |  |   |  |   |   |  |
| 29c. License number<br><b>D39813</b>   |  |                                | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>   |   |  |  |   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. A. H. S. 1104 Westbury Drive Sparks MD 21804</b>   |  |                                |   |   |  |  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |  |                                | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |   |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene 99 12011

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUFUS WASHINGTON BRIDDELL

2. Date of Death

Month Day Year  
March 29, 1999

3. Time of Death

0413

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENNINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

214-28-3372

6. Sex

XX M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAY 15, 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

WORCESTER

10c. City, Town or Location

BISHOPVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9619 PEERLESS ROAD

10f. Zip Code

21813

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 42 - 45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

NURSERY WORKER

16b. Kind of Business/Industry

AGRICULTURE

17. Father's Name (First, Middle, Last)

KENDALL JAMES BRIDDELL

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA WRIGHT

19a. Informant's Name/Relationship (Type, Print)

NATALIE MUMFORD - SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13306 OLD STAGE RD., BISHOPVILLE, MD. 21813

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CURTIS CEMETERY

Date

4/3/99

20c. Location - City or Town, State

BISHOPVILLE, MD.

21. Signature of Funeral Service Licensee

Richard T. Watson

22. Name and Address of Facility

WATSON FUNERAL HOME, INC., MILLSBORO, DELAWARE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Approximate Interval Between Onset and Death

Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Ischemic cardiomyopathy

Due to (or as a consequence of):

Coronary artery disease

Due to (or as a consequence of):

Kidney Failure

Months

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Kidney Failure

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Constante J. Tan M.D.

29c. License number

16725

29d. Date signed (Month, Day, Year)

3/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

547-G Riverside Dr. Salisbury, MD 21801

CONSTANTE J TAN

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

Geneva B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
214-28-3372  
RUFUS W. BRIDDELL  
Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLARENCE BLAKE

2. Date of Death

Month

Day

Year

MARCH 29, 1999

3. Time of Death

0555

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

214-28-1508

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

OCT. 14, 1932

9. Birthplace (State or Foreign Country)

STOCKTON, MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

WORCESTER

10c. City, Town or Location

STOCKTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6026 PORTERSVILLE ROAD

10f. Zip Code

21864

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRO-AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

BARBER/SWANSON FOODS

17. Father's Name (First, Middle, Last)

CLARENCE FOREMAN

18. Mother's Name (First, Middle, Maiden Surname)

MARY BLAKE

19a. Informant's Name/Relationship (Type, Print)

IRETHA BLAKE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

ADDRESS SAME AS ABOVE

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. PAUL UM CHURCH CEM.

Date

4-2

20c. Location - City or Town, State

STOCKTON, MD.

21. Signature of Funeral Service Licensee

*Loretta B. Jolley*

22. Name and Address of Facility

JOLLEY MEMORIAL CHAPEL

1213 JERSEY road; SALISBURY, MD. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Infection*

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

*Decubitus, venous catheters*

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*days*  
*weeks*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*CUA, kidney failure*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury of Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Constantine Tan*

29c. License number

*16725*

29d. Date signed (Month, Day, Year)

*3/29/99*

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

*TAN, CONSTANTINE 547-G Riverside Dr, Salisbury, MD 21801*

31. Date filed (Month, Day, Year)

*MAR 31 1999*

32. Registrar's Signature

*[Signature]*

State  
Registrar

CLARENCE BLAKE  
214-28-1508

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12013

|                                     |  |  |   |                                |  |
|-------------------------------------|--|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BLANCHE HOPKINS BURGESS</b>   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 16 1999</b>  |                                | 3. Time of Death<br><b>12:14 PM</b>  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN NURSING CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>214-38-2686</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 31, 1906</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |                                |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent  |  | 10a. State<br><b>MARYLAND</b>   |                                | 10b. County<br><b>BALTIMORE</b>  |
|                                     | 10c. City, Town or Location<br><b>ELLICOTT CITY</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                |  |
|                                     | 10e. Street and Number<br><b>2521 WESTCHESTER AVE.</b>   |  | 10f. Zip Code<br><b>21043</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |                                |  |
|                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TEACHER</b>  |  | 16b. Kind of Business/Industry<br><b>PUBLIC SCHOOLS</b>   |                                |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>JOHN THOMAS HOPKINS</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MINNIE BELLE DASHIELL</b>   |                                |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>BARBARA H. LANG - NIECE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>209 MIDHURST RD. BALTIMORE, MD 21212</b>  |                                |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARSONS CEMETERY</b>   |                                | 20c. Location - City or Town, State<br><b>3-20-99 SALISBURY, MARYLAND</b>  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>B. Keith P. Jones, CFS</b>   |  | 22. Name and Address of Facility<br><b>705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804</b>  |                                |  |
| Physician<br>/Medical<br>Examiner   | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CHRONIC PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br>b. <b>CHRONIC PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                | Approximate Interval Between Onset and Death<br><b>10 min</b><br><b>70 yrs</b>   |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>FEVERILE ILLNESS</b>  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|                                     | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |                                |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |                                |  |
|                                     | 29b. Signature and title of certifier<br><b>Charles F. Hoesch, M.D.</b>  |  | 29c. License number<br><b>D 20390</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>3/22/99</b>  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHARLES HOESCH, M.D. 5601 LOCH RAVEN BLVD. 3RD FLOOR BALTIMORE, MD 21239</b>  |  |   |                                |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>  |  | 32. Registrar's Signature<br><b>Geneva B. Sparks</b>  |                                |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

12014

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Sidney A. Britten

2. Date of Death  
Month Day Year  
MARCH 11, 1999

3. Time of Death

11:32 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

081-32-9164

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 12, 1905

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Woodbine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2716 Jennings Chapel Road

10f. Zip Code

21797

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

George Britten

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

John S. Britter/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2716 Jennings Chapel Road Woodbine, MD 21797

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

3-12-99

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Shirley A. Collins-Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OLD MYOCARDIAL INFARCTION

CORONARY ARTERY DISEASE.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

051245

29d. Date signed (Month, Day, Year)

MARCH, 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAJID SHARIF NORTH ARUNDEL HOSPITAL - MD

31. Date filed (Month, Day, Year)

MAR 15 1999

32. Registrar's Signature

G. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

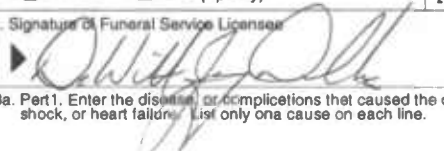
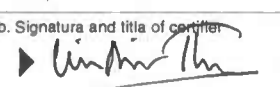



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12015

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |  |  |   |  |
|--|---|---|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ANNA BERTLING</b>                                |   |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 17 1999</b> |  |  |  | 3. Time of Death<br><b>1:42 PM</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  |  |  | 4c. County of Death<br><b>Baltimore</b>                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-10-4526</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB 24, 1909</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | Usual Residence of Decedent   |   |  |  |  |  |  |  |   |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>1701 Wren Way</b>   |   |   |  | 10f. Zip Code<br><b>21060</b>  |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 12</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>United States Government</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Bernard Joseph Bertling</b>  |   |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gertrude Youse</b>           |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marguerite Knowles /sister</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1204 June Road, Arbutus, Maryland 21227</b>  |  |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | Date<br><b>3/18/99</b>   |  | 20c. Location - City or Town, State<br><b>Catonsville, Maryland</b>                  |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707-4389</b>   |  |  |  |  |   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>MYOCARDIAL INFARCTION</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>GASTRO INTESTINAL BLEEDING</b> |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>6 DAYS</b><br><b>5 DAYS</b>   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>GASTRO INTESTINAL BLEEDING</b>  |   |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br> <b>RESIDENT INTERNAL MEDICINE</b>  |  | 29c. License number<br><b>P 10641</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 17 1999</b>                          |  |  |   |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>WIN MIN THU, MD HARBOR HOSPITAL CENTER BALTIMORE MD 21225</b>   |   |   |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1999</b>  |   | 32. Registrar's Signature<br>   |  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amended #17 &amp; #18, 03/26/99, PCT, Howard

99 12016

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Heather Marie Mooney Bell

2. Date of Death

Month

Day

Year

March 20 1999

3. Time of Death

10:40pm

4a. Facility Name (If not institution, give street and number)

7925 Anfred Drive

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Howard

5. Social Security Number

219-68-3018

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

28

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 28, 1970

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9318 Katie Lane

10f. Zip Code

20723

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Assistant

16b. Kind of Business/Industry

Healthcare

17. Father's Name (First, Middle, Last)

Sandra M. Navitski

John A. Mooney

18. Mother's Name (First, Middle, Maiden Surname)

John A. Mooney

Sandra M. Navitski

19a. Informant's Name/Relationship (Type, Print)

John A. Mooney/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7925 Anfred Drive Laurel, Maryland 20723

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Louis Cemetery

Date

3-23-99

20c. Location - City or Town, State

Clarksville, MD

21. Signature of Funeral Service Licensee

Sharon A. Collins-Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aspiration Pneumonia

Due to (or as a consequence of):

4 weeks

c. Cervical cancer stage IV

Due to (or as a consequence of):

18 months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Liver Failure, Renal Failure

GI obstruction, Anemia

Aspirates

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John K. Muli MD

29c. License number

D 30573

29d. Date signed (Month, Day, Year)

March 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John K. Muli MD

31. Date filed (Month, Day, Year)

MAR 22 1999

32. Registrar's Signature

Sandra B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |   |  |  |
|---|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BARBARA Ann BUNNELL</b>                              |   |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>26</b> Year <b>1999</b> |   | 3. Time of Death<br><b>2222</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>284-32-5237</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 25, 1935</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>  |
|   | Usual Residence of Decedent   |   |  |  | 10c. City, Town or Location<br><b>Jessup</b>                          |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Howard</b>  |  | 10e. Street and Number<br><b>8205 Washington Blvd. Lot 42</b>  |   | 10f. Zip Code<br><b>20794</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 12</b>  |   | College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>  |   | 16b. Kind of Business/Industry<br><b>Dept. of the Navy</b>                                  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert Norman</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Iona Hall</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Donna Shifflett / daughter</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>420 Woodside Road Riva, Maryland 21140</b>   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Md. Veterans Cemetery</b>  |  | Date<br><b>4/1/99</b>  |   | 20c. Location - City or Town, State<br><b>Crownsville, Md.</b>                              |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Avenue Laurel, Maryland 20707</b>  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><b>b. ISCHEMIC CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |   |   |  | Approximate Interval Between Onset and Death<br><b>8 YEARS</b><br><b>8 YEARS</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL FAILURE</b>  |   |   |  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Kyrsten D. Fairbanks, M.D.</b>  |   |   |  | 29c. License number<br><b>RES-000</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 26, 1999</b>                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>KYRSTEN D. FAIRBANKS, M.D., JHH, TOWER 110, BALTIMORE, MD 21205</b>  |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |   | 32. Registrar's Signature<br>   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12018

|   |   |   |   |   |   |   |  |  |
|---|---|---|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Harry Wesley Beall</b>                                   |   |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>28</b> Year <b>1999</b> |   | 3. Time of Death<br><b>02:00AM</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>VA Maryland Health Care System</b> |   |   |   | 4b. City, Town, or Location of Death<br><b>Perry Point</b>            |   | 4c. County of Death<br><b>Cecil</b>                        |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-03-9564</b>   |   | 6. Sex<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>May 01, 1915</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Howard</b>  |   | 10c. City, Town or Location<br><b>Laurel</b>               |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>9547 Linville Avenue</b>   |   | 10f. Zip Code<br><b>20723</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Grade 4</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>  |   | 16b. Kind of Business/Industry<br><b>Long Distance Hauling</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Harry Beall</b>   |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gertrude Watts</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Penny Klages /daughter</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2886 Aquamarine Circle, Rescue, California 95672</b>  |   | 20a. Method of Disposition<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify) |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Pk</b>  |   | 20c. Date<br><b>3/31/99</b>   |   | 20d. Location - City or Town, State<br><b>Dorsey, Maryland</b>  |   | 21. Signature of Funeral Service Licensee<br>   |  |  |
| 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707-4389</b>  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>Laryngeal cancer</b><br>Due to (or as a consequence of):<br><br>b. <b>Prostate cancer</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death<br><br><b>Unknown</b><br><br><b>Unknown</b>  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown                                 |  |  |
| 24a. Was an autopsy performed?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No   |   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease, Dehydration,</b><br><b>Tracheostomy</b>   |   | 25. Was case referred to medical examiner?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury</b><br><b>M</b><br><b>28c. Injury at Work?</b><br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No  |   | 28d. Describe how Injury occurred   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>  |  |  |
| 29c. License number<br><b>D50454</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>March 28, 1999</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARASTOO YAZDANI, M.D., VA Maryland Health Care System, Perry Point, MD 21902</b>   |   | 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |  |  |
| 32. Registrar's Signature<br>  |   |   |   |   |   |   |  |  |

NAME KNOWN TO PHYSICIAN: HARRY W. BEALL  
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12019

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Maria Chicas

2. Date of Death

Month Day Year  
March 25, 1999

3. Time of Death

6:50 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

None

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 25, 1999

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2215 Georgian Way, #11

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: El Salvadoran

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Dinora Chicas

19a. Informant's Name/Relationship (Type, Print)

Dinora Chicas (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2215 Georgian Way, #11, Wheaton, Maryland 20902

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

3-31-99

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Carol A. ...

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PREMATURITY AT 20 WKS GESTATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PULMONARY INSUFFICIENCY

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHORIO AMNIONITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary Lenore Keszler, M.D.

29c. License number

D28060

29d. Date signed (Month, Day, Year)

3-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Lenore Keszler, M.D.

HOLY CROSS HOSPITAL 1500 FOREST GLEN RD SILVER SPRING, MD.

20910

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12020

## Certificate of Death

Reg. No.

|  |  |   |  |                                      |   |   |   |                                   |   |  |
|--|--|---|--|--------------------------------------|---|---|---|-----------------------------------|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES HOWARD CISSEL</b>   |   |  |                                      | 2. Date of Death<br>Month Day Year<br><b>MARCH 31, 1999</b>   |   |   |                                   | 3. Time of Death<br><b>13:55</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MONTGOMERY GENERAL HOSPITAL</b>   |   |  |                                      | 4b. City, Town, or Location of Death<br><b>OLNEY</b>  |   |   |                                   | 4c. County of Death<br><b>MONTGOMERY</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577 42 1090</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |                                      | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 2, 1931</b>              |                                   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |
|  | Usual Residence of Decedent  |   |  |                                      | 10a. State<br><b>MD.</b>  |   | 10b. County<br><b>MONTGOMERY</b>  |                                   | 10c. City, Town or Location<br><b>GAITHERSBURG</b>  |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>24409 HANSON ROAD</b>   |   |  |                                      | 10f. Zip Code<br><b>20882</b>   |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                   |                                   |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>1951-</b><br>If Yes, Give Year or Dates: <b>1953</b>   |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                   |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ARBORIST</b>  |                                      | 16b. Kind of Business/Industry<br><b>TREE SURGERY</b>   |   |   |                                   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM E. CISSEL</b>  |   |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELLEN LOVEJOY</b>   |   |   |                                   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MELLIE D. CISSEL, WIFE</b>  |   |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24409 HANSON ROAD, GAITHERSBURG, MD. 20882</b>  |   |   |                                   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>   |                                      | Date<br><b>4/3/99</b>   |   | 20c. Location - City or Town, State<br><b>SILVER SPRING, MD.</b>        |                                   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Muriel H. Barber</b>   |   |  |                                      | 22. Name and Address of Facility<br><b>MURIEL H. BARBER FUNERAL HOME<br/>P.O. BOX 5038, LAYTONSVILLE, MD. 20882</b>   |   |   |                                   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Ventricular Fibrillation</b><br>Due to (or as a consequence of):<br><b>Ischemic Cardiomyopathy</b><br>Due to (or as a consequence of):<br><b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Hypertension</b><br><b>Hypolipidemia</b> |   |  |                                      |   |   |   |                                   | Approximate Interval Between Onset and Death<br><b>8 years</b><br><b>10 years</b>   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Hypolipidemia</b>  |   |  |                                      |   |   |   |                                   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                      |   |   |   |                                   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)                      |  | 28b. Time of Injury<br><b>M</b>      |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b> |  | 29c. License number<br><b>D21334</b> |   | 29d. Date signed (Month, Day, Year)<br><b>March 31, 1999</b>                                |   |                                   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6116 Executive Blvd. Rockville, Maryland 20852</b>  |  |   |  |                                      |   |   |   |                                   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 02 1999</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>             |  |                                      |   |   |   |                                   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

(4)

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #1 PER MD G770 4-26-99 WR.

## Certificate of Death

Reg. No.

99 12021

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNE  
Ann Whitney Clark2. Date of Death  
Month Day Year

March 30, 1999

3. Time of Death

7:15pm

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

405-24-7449

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 8, 1925

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

334 East Diamond Avenue #4

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Labor Union

17. Father's Name (First, Middle, Last)

Maurice Vernon Clark

18. Mother's Name (First, Middle, Maiden Surname)

Miriam Galloway

19a. Informant's Name/Relationship (Type, Print)

Martha Clark Lott (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2108 Scherm Road, Owensboro, KY 42301

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan CREmatory

Data

3/31/99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Robert H. Welch

22. Name and Address of Facility DeVol Funeral Home

10 East Deer Park Drive  
Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Chronic Posttraumatic pulmonary disease years

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alan S. Chanale MD

29c. License number

29453

29d. Date signed (Month, Day, Year)

March 31 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

ALAN CHANALE 1515 SHADY GROVE RD ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12022

|   |   |   |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
|---|---|---|---|--|--|--|--|--|--|---|----|------------------------|---------|----------------------------------|--|--|----|---------------------|--------|----------------------------------|--|--|----|-----------|-------|----------------------------------|--|--|----|----------|---------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>James W. Clatterbuck                      |   |   |  |  | 2. Date of Death<br>Month Day Year<br>March 25, 1999                                 |  | 3. Time of Death<br>11:42 PM   |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
|   | 4a. Facility Name (If not institution, give street and number)<br>HOLY CROSS HOSPITAL |   |   |  |  | 4b. City, Town, or Location of Death<br>SILVER SPRING                                |  | 4c. County of Death<br>MONTGOMERY  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| Funeral<br>Director   | 5. Social Security Number<br>223-22-7151  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>81 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>June 17, 1917 |  | 9. Birthplace (State or Foreign Country)<br>Missouri |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 10a. State<br>MD  |   | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Rockville |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 10e. Street and Number<br>4304 Elizabeth Street   |   |   |   |  | 10f. Zip Code<br>20853   |  | 10g. Citizen of What Country?<br>United States       |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+)  |   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Self employed   |  |  | 16b. Kind of Business/Industry<br>Painting   |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 17. Father's Name (First, Middle, Last)<br>Stonewall Jackson Clatterbuck  |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Martha Smedley  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 19a. Informant's Name/Relationship (Type, Print)<br>Carol L. Clatterbuck/Daughter   |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4304 Elizabeth Street, Rockville, MD 20853  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montgomery Crematorium  |  |  | Date<br>March 28, 1999   |  | 20c. Location - City or Town, State<br>Bethesda, Maryland  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 21. Signature of Funeral Service Licensee<br>William A. Humphrey MO1173   |   |   |   |  | 22. Name and Address of Facility<br>Robert A. Humphrey Funeral Home, Rockville, Inc.<br>300 West Montgomery Avenue, Rockville, MD 20850-2805   |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Cardiopulmonary arrest</td> <td>30 min.</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Respiratory failure</td> <td>8 hrs.</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Pneumonia</td> <td>1 day</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Dementia</td> <td>2 years</td> </tr> </table> |   |   |   |  |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Cardiopulmonary arrest | 30 min. | Due to (or as a consequence of): |  |  | b. | Respiratory failure | 8 hrs. | Due to (or as a consequence of): |  |  | c. | Pneumonia | 1 day | Due to (or as a consequence of): |  |  | d. | Dementia | 2 years |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.  | Cardiopulmonary arrest  | 30 min.   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
|   | Due to (or as a consequence of):  |   |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
|   | b.  | Respiratory failure   | 8 hrs.  |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
|   | Due to (or as a consequence of):  |   |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| c.  | Pneumonia   | 1 day   |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| Due to (or as a consequence of):  |   |   |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| d.  | Dementia  | 2 years   |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Clostridium difficial colitis   |   |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                 |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 29b. Signature and title of certifier<br>Jennell M.D.   |   |   |   |  | 29c. License number<br>D05174  |  | 29d. Date signed (Month, Day, Year)<br>MAR 26, 1999  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Latindex Sekhon M.D. 2401 Research Blvd #102 Rockville MD 20850   |   |   |   |  |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |
| State Registrar   |   | 31. Date filed (Month, Day, Year)<br>MAR 29 1999  |   | 32. Registrar's Signature<br>G. Sparks   |  |  |  |  |  |   |    |                        |         |                                  |  |  |    |                     |        |                                  |  |  |    |           |       |                                  |  |  |    |          |         |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99-12023**  
**Certificate of Death**

Reg. No.

|   |  |                                    |   |   |  |   |   |  |  |  |
|---|--|------------------------------------|---|---|--|---|---|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Angelo Joseph Corte</b>                               |                                    |   |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>25</b> Year <b>1999</b> |   |  | 3. Time of Death<br><b>1544</b>                                |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b> |                                    |   |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>              |   |  | 4c. County of Death<br><b>Anne Arundel</b>                     |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>428-40-4036</b>  |                                    | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>June 17, 1929</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>Mississippi</b> |  |
|   | Usual Residence of Decedent  |                                    |   |   |  |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b> |   | 10c. City, Town or Location<br><b>Edgewater</b> |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>24 Shadow Point Court</b>  |  |                                    |   |   | 10f. Zip Code<br><b>21037</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>   |  |                                    |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Professor</b>  |   |   | 16b. Kind of Business/Industry<br><b>University</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Peter Corte</b>   |  |                                    |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eleanora Masini</b>  |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Peter J. Corte/son</b>   |  |                                    |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24 Shadow Point Court, Edgewater, Maryland 21037</b>                                     |   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |   |  | Date<br><b>March 30, 1999</b>   |   | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>                                |  |  |
| 21. Signature of Funeral Service Licensee<br> <b>M00803</b>   |  |                                    |   |   | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/<br/>Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave.<br/>Bethesda, Maryland 20814-3501</b>                             |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                                    |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Cerebrovascular accident</b></p> <p>Due to (or as a consequence of):</p> </div> <div style="width: 65%;"> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 5%; text-align: center;"> <p>unknown</p> </div> </div> |  |                                    |   |   |  |   |   |  |  |  |
| <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>_____</p> <p>_____</p>   |  |                                    |   |   |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |                                    |   |   |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                    |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                    | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |                                    | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                              |  |
|   |  |                                    | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                                    |   |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  |                                    |   |   | 29c. License number<br><b>D26743</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/26/99</b>                                       |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H.D. Goldstein, MD - 205 Ridgely Ave Annap, Md.</b>  |  |                                    |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |  |                                    | 32. Registrar's Signature<br>  |   |  |   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12024

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Foster Covington

2. Date of Death

Month  
MARCHDay  
25Year  
1999

3. Time of Death

6:25 PM

4a. Facility Name (If not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

412-24-8459

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 31, 1920

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1614 Crittenden Street N.W.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Clesie Bryant Foster

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jane Phillips

19a. Informant's Name/Relationship (Type, Print)

James P. Covington, Jr. - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1614 Crittenden Street N.W., Washington, DC 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cem.

Date

4/5/99

20c. Location - City or Town, State

Ft. Myer, Virginia

21. Signature of Funeral Service Licensed

22. Name and Address of Facility

McGuire Funeral Service, Inc.

7400 Georgia Ave. N.W., Washington, D.C.

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Urinary Tract Infection

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to Immediate  
Cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration Pneumonia

Congestive Heart Failure

Hypertensive Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R.G. BHOTRAJ-MD 704 Gorman Ave #T-1 Laurel, MD 20707

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

ELIZABETH F. Covington



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12025

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Hilton Crouch

2. Date of Death

Month Day Year  
March 30, 1999

3. Time of Death

7:48a.m.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

5707 S. Hawthorne Avenue (Residence)

4b. City, Town, or Location of Death

Rock Hall

4c. County of Death

Kent

5. Social Security Number

214-32-7479

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 3, 1909

9. Birthplace (State or Foreign Country)

Rock Hall, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Rock Hall

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5707 S. Hawthorne Avenue

10f. Zip Code

21661

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

18e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Waterman

16b. Kind of Business/Industry

Seafood

17. Father's Name (First, Middle, Last)

Joseph Lemuel Crouch

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Cecil

19e. Informant's Name/Relationship (Type, Print)

Fernande Crouch/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5707 S. Hawthorne Ave., Rock Hall, MD 21661

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Wesley Chapel Cemetery

Date

4/2/99

20c. Location - City or Town, State

Rock Hall, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.  
130 Speer Road, Chestertown, MD 2162023a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. UPPER GASTROINTESTINAL BLEEDING

Approximate  
Interval Between  
Onset and Death

~1 hour

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D41587

29d. Date signed (Month, Day, Year)

4/1/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Helen A. Noble 122 Speer Road, Suite 5, Chestertown, MD 21620

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12026

Certificate of Death

Reg. No.

|  |  |   |  |  |   |   |   |  |
|--|--|---|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Charles Frederick Cougnet</b>                     |   |  |  | 2. Date of Death<br>Month Day Year<br><b>March 27 1999</b>    |   | 3. Time of Death<br><b>2:45AM</b>                           |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>264 Lewis Street Apt. C</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b> |   | 4c. County of Death<br><b>Harford</b>                       |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-12-8077</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.              |   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 27, 1924</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                      |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b>                                 |   | 10c. City, Town or Location<br><b>Havre de Grace</b>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>264 Lewis Street Apt. C</b>  |  | 10f. Zip Code<br><b>21078</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Security</b>  |  | 16b. Kind of Business/Industry<br><b>Prison</b>  |   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Cougnet</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNK</b>  |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sharon L. Mills (Daughter)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>264 Lewis Street, Apt. C, Havre de Grace, MD 21078</b>                                   |   |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R. A. Ferris &amp; Co., Inc.</b>   |  | 20c. Date<br><b>3/29/99</b>  |   | 20d. Location - City or Town, State<br><b>West Chester, PA</b>                              |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Kenneth B. Gays</i>  |  |   |  | 22. Name and Address of Facility<br><b>Tarring-Cargo Funeral Home, P.A.<br/>Aberdeen, Maryland 21001-3399</b>  |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>metastatic lung cancer</b><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>History of myocardial infarction</b><br><b>History of coronary artery disease</b>   |  |   |  |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |   |   |  |
| 29b. Signature and title of certifier<br><i>H. Sup Sim</i>   |  | 29c. License number<br><b>D46412</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>  |   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H. Sup Sim 319 S. Union Ave Havre de Grace MD 21078</b>   |  |   |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>  |  | 32. Registrar's Signature<br><i>James B. [Signature]</i>  |  |  |   |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |   |  |  |
|--|--|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES HENRY CLINTON</b>                             |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>19</b> Year <b>1999</b> |   | 3. Time of Death<br><b>10:27 AM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Fallston General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Fallston</b>               |   | 4c. County of Death<br><b>Harford</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-32-2773</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>7/4/1920</b>   | 9. Birthplace (State or Foreign Country)<br><b>N. Carolina</b>   |
|  | Usual Residence of Decedent  |   |  |  |   |   |  |  |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Jarrettsville</b>  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>4090 Federal Hill Road</b>  |  |   |  | 10f. Zip Code<br><b>21084</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>-</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |   | 16b. Kind of Business/Industry<br><b>Canning House</b>                                      |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Bryant Emanuel Clinton</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Mary Elizabeth Hardy</b>   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lynn A. Clinton/Niece</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as #10</b>  |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. James Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>1999 Jarrettsville, Md.</b>                       |  |  |
| 21. Signature of Funeral Service Licensee<br><i>M. Blackden Kurtz III</i>  |  |   |  | 22. Name and Address of Facility<br><b>E.G. Kurtz &amp; Son Funeral Home, P.A.<br/>Jarrettsville, Maryland 21084</b>   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>BILATERAL PNEUMONIA</b>  |  |   |  |  |   |   |  | Approximate Interval Between Onset and Death<br><b>1 DAY</b>   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br><i>Andrew Nowakowski MD</i>   |   | 29c. License number<br><b>008096</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 19, 1999</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANDREW NOWAKOWSKI MD 125 N. MAIN ST. BALTIMORE MD</b>   |  |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 24 1999</b>  |  |   |  | 32. Registrar's Signature<br><i>B. Sparks</i>  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

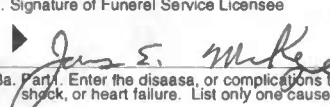
**CEREBROVASCULAR ACCIDENT**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12028**  
Certificate of Death

Reg. No.

|   |  |                                |  |   |  |   |   |  |                                |   |   |   |   |   |  |
|---|--|--------------------------------|--|---|--|---|---|--|--------------------------------|---|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Nellie N. Clise</b>                             |                                |  |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 20, 1999</b> |  |                                | 3. Time of Death<br><b>20:40 PM</b>   |   |   |   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b> |                                |  |   |  |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  |                                | 4c. County of Death<br><b>Allegany</b>  |   |   |   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-74-6797</b>  |                                | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs. |   | If Under 1 Year<br>Months Days                              |  | If Under 24 Hrs.<br>Hours Min. |   | 8. Date of Birth (Month, Day, Year)<br><b>July 7 1909</b> |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |   |  |
|   | Usual Residence of Decedent  |                                |  |   |  |   |   |  |                                |   |   |   |   |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Allegany</b> |  | 10c. City, Town or Location<br><b>Midland</b>   |  |   |   |  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |  |
| 10e. Street and Number<br><b>14500 Flint Road SW</b>  |  |                                |  |   |  | 10f. Zip Code<br><b>21542</b>   |   |  |                                | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+) <b>0</b>   |  |                                |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   |  |                                | 16b. Kind of Business/Industry<br><b>Home</b>   |   |   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Patrick Nelson</b>  |  |                                |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Buskirk</b>  |   |  |                                |   |   |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda Cutter daughter</b>  |  |                                |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14500 Flint Road SW, Midland, MD 21542</b>  |   |  |                                |   |   |   |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Frostburg Memorial Park</b>  |   |  |                                | Date<br><b>March 23 1999</b>  |   | 20c. Location - City or Town, State<br><b>Frostburg, MD</b>             |   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                |  |   |  | 22. Name and Address of Facility<br><b>Eichhorn-McKenzie Funeral Home P.A.<br/>Lonaconing, MD</b>   |   |  |                                |   |   |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                |  |   |  |   |   |  |                                |   |   |   |   | Approximate Interval Between Onset and Death<br><b>3 Day</b><br><b>About 10 yrs</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b><br><b>HYPERTENSION. DEMENTIA</b>   |  |                                |  |   |  |   |   |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |                                |   |   |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |                                |   |   |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |                                |  |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred                                       |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                |  |   |  | 29b. Signature and title of certifier<br>  |   |  |                                | 29c. License number<br><b>226907</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 21, 1999</b>            |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Hargit Sidhu M.D. 925 Bishop Walsh Road Cumberland MD 21502</b>  |  |                                |  |   |  |   |   |  |                                |   |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 24 1999</b>   |  |                                |  |   |  | 32. Registrar's Signature<br>  |   |  |                                |   |   |   |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12029

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Mary Virginia Cote  
2. Date of Death Month 03 Day 22 Year 1999 3. Time of Death 8:00PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Moran Manor Nursing Home  
4b. City, Town, or Location of Death Westernport, MD 4c. County of Death Allegany

5. Social Security Number 220-24-5181 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last birthday) 76 Yrs. 8. Date of Birth (Month, Day, Year) 01-19-1923 9. Birthplace (State or Foreign Country) WV

Usual Residence of Decedent 10a. State Maryland 10b. County Allegany 10c. City, Town or Location Westernport 10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 25701 Shady Lane SW 10f. Zip Code 21562 10g. Citizen of What Country? Yes United States

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse 16b. Kind of Business/Industry State of Maryland

17. Father's Name (First, Middle, Last) Joseph S. Gleeson 18. Mother's Name (First, Middle, Maiden Surname) Mary C. Mullen

19a. Informant's Name/Relationship (Type, Print) John A. Martin Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Central Avenue Westernport, MD 21562

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peters Cemetery Date 3/86/99 20c. Location - City or Town, State Westernport, MD

21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fredlock Funeral Home PO Box 4 Piedmont, WV 26750

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of Lung Due to (or as a consequence of): 3 months b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease Respiratory Failure 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number D21244 29d. Date signed (Month, Day, Year) 3/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan, M.D., Frostburg Plaza, Frostburg, Maryland 21532

31. Date filed (Month, Day, Year) MAR 29 1999 32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12030

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Edna M. Cruthers</b>  |  | 2. Date of Death<br>Month <b>Apr</b> Day <b>2</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>12:00 pm</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Devlin Manor Nursing Home</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |  | 4c. County of Death<br><b>Allegany</b>   |
| 5. Social Security Number<br><b>216-22-6746</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan 18, 1920</b>   |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Allegany</b>   | 10c. City, Town or Location<br><b>Cumberland</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>35 Boone Street</b>   |  | 10f. Zip Code<br><b>21502</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>NFN</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NMN</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sandy Turner-granddaughter</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6D Fort Cumberland Homes; Cumberland, MD 21502</b> |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rocky Gap Veterans Cem.</b>  |  | Date<br><b>04/06</b>   | 20c. Location - City or Town, State<br><b>Flintstone MD</b>  |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home, P.A.<br/>Cumberland MD 21502</b>  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><br>b. <b>CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |   |  |  | Approximate Interval Between Onset and Death<br><br><b>1 month</b><br><br><b>5 yrs.</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>CHRONIC LUNG DISEASE</b>  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D23334</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 5th 1999</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Dinesh Shah 625 Kent Avenue Cumberland MD 21502</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 05 1999</b>  |  | 32. Registrar's Signature<br>   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12031

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERNICE VIRGINIA CAHALL

2. Date of Death

Month

Day

Year

March

23, 1999

1500

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENNINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

222-26-4036

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

AUG 26, 1918

9. Birthplace (State or Foreign Country)

NEW HAMPSHIRE

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

SELBYVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

COUNTY ROAD 388 (P.O. BOX 608)

10f. Zip Code

19975

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married2 ☐ Married3 ☒ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LOUIS RYAN

18. Mother's Name (First, Middle, Maiden Surname)

HILDA HANSCHUMAKER

19e. Informant's Name/Relationship (Type, Print)

NORMA JEAN SMITH / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 608, SELBYVILLE, DELAWARE 19975

20a. Method of Disposition

1 ☒ Burial2 ☐ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

REDMAN'S CEMETERY

Date

3/26/99

20c. Location - City or Town, State

SELBYVILLE, DELAWARE

21. Signature of Funeral Service Licensee

Richard T. Watson

22. Name and Address of Facility

WATSON FUNERAL HOME, INC.

211 WASHINGTON STREET, MILLSBORO, DELAWARE 19966

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Myocardial Infarction

Due to (or as a consequence of):

b.

Coronary Artery Disease

Due to (or as a consequence of):

c.

Congestive Heart Failure

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dense Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

M

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

0040715

29d. Date signed (Month, Day, Year)

3/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Hays, MD 4100 Eastern Shore Dr. Salisbury, MD 21808

31. Date filed (Month, Day, Year)

MAR 25 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



JOHN CINOTTI

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12032

|  |  |  |   |  |   |  |  |   |  |
|--|--|--|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>John Thomas Cinotti, Sr.</b>                                  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 15, 1999</b> |  | 3. Time of Death<br><b>2014 PM</b>                         |   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>UNIVERSITY OF MARYLAND-SHOCK TRAUMA</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>    |  | 4c. County of Death<br><b>Baltimore</b>                    |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>113-28-4451</b>  |  | 6. Sex<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT 20, 1935</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>                          |  | 10c. City, Town or Location<br><b>Laurel</b>               |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>224 Spring Gap South</b>  |   | 10f. Zip Code<br><b>20724</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                   |  |
| 11. Marital Status<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Grade 12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electronics Technician</b>   |   | 16b. Kind of Business/Industry<br><b>Department of Navy</b>  |   |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Vincent Cinotti</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Fox</b>  |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Theresa Cinotti /daughter</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>226 Spring Gap South, Laurel, Maryland 20724</b>   |   |  |  |   |  |
| 20a. Method of Disposition<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>3/20/99 Glen Burnie, Maryland</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |   | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707-4389</b>   |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |  |   | Approximate Interval Between Onset and Death   |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown |  |   |  |
|  |  |  |   |  |   | 24a. Was an autopsy performed?<br><b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No  |  |   |  |
|  |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input checked="" type="checkbox"/> Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |   |  |   |  |  |   |  |
| 27. Manner of Death<br><b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>3 15 99</b>   |   | 28b. Time of Injury<br><b>6:00 P M</b>   |   | 28c. Injury at Work?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>FELL OFF THE ROOF</b> |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>AT HOME</b>   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>224 SPRING GAP SOUTH A Laurel</b>   |  |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                 |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 17, 1999</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mary Theresa Cinotti 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1999</b>  |  | 32. Registrar's Signature<br>  |   |  |   |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12033

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH ALBERT CAPPELLETTI

2. Date of Death

MAR 23 1999 0645

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

214-03-7221

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 12, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8419 Jopenda Drive

10f. Zip Code

21043

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1942-4513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

John Cappelletti

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Appacella

19a. Informant's Name/Relationship (Type, Print)

Joseph A. Cappelletti Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11875 Frederick Road Ellicott City, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest Vet. Cem. 3-29-99

Date

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Shawn A. Collins-Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 20 YRS

Due to (or as a consequence of):

c. AORTIC STENOSIS 20 YRS

Due to (or as a consequence of):

d. MITRAL STENOSIS 20 YRS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

EXPLORATORY LAPAROTOMY 3/18/99 TO  
IDENTIFY SOURCE OF GI BLEEDING IN  
JETUNUM - SOURCE NOT FOUND.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael G. Witzke MD.

29c. License number

D30763

29d. Date signed (Month, Day, Year)

Mar 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL G. WITZKE 11085 LITTLE PATUKENT PKWY, #102 COLOMBIA MD 21044

31. Date filed (Month, Day, Year)

MAR 26 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12034

|   |  |   |  |  |  |  |   |  |  |   |
|---|--|---|--|--|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Edward H. Dassing  |   |  |  | 2. Date of Death<br>Month Day Year<br>March 31, 1999 |  |   |  | 3. Time of Death<br>4:00 PM                    |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Potomac Valley Nursing & Wellness Center |   |  |  | 4b. City, Town, or Location of Death<br>Rockville    |  |   |  | 4c. County of Death<br>Montgomery              |   |
| Funeral<br>Director   | 5. Social Security Number<br>136-05-3982   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>83 Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br>Jan 5 1916 |  | 9. Birthplace (State or Foreign Country)<br>NJ |   |
|   | Usual Residence of Decedent  |   |  |  |  |  |   |  |  |   |
| 10a. State<br>MD  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Silver Spring   |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |
| 10e. Street and Number<br>1613 Cody Drive   |  |   |  | 10f. Zip Code<br>20902   |  |  |   | 10g. Citizen of What Country?<br>USA   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates 1942-1945  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 2  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Official  |  |  |   | 16b. Kind of Business/Industry<br>Government   |  |   |
| 17. Father's Name (First, Middle, Last)<br>Otto J. Dassing  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bertha Zwigard  |  |  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Doris M. Dassing / Wife   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1613 Cody Drive, Silver Spring, MD 20902  |  |  |   |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery  |  |  |   | 20c. Location - City or Town, State<br>Silver Spring, MD   |  |   |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>Collins Funeral Home<br>500 University Blvd W., Silver Spring, MD 20901  |  |  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Cardiopulmonary arrest</u>   |  |   |  |  |  |  |   |  |  | 24 hours  |
| Due to (or as a consequence of):<br>b. <u>Chronic renal failure</u>   |  |   |  |  |  |  |   |  |  | years   |
| Due to (or as a consequence of):<br>c. <u>Cardiovascular disease</u>  |  |   |  |  |  |  |   |  |  |   |
| Due to (or as a consequence of):<br>d. _____  |  |   |  |  |  |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |  |   |  |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br>D52261  |  |  |   | 29d. Date signed (Month, Day, Year)<br>April 1, 1999   |  |   |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br>Alan R. Segal, M.D., 1299 Lambertson Drive, Silver Spring, MD 20902   |  |   |  |  |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>APR 02 1999  |  |   |  | 32. Registrar's Signature<br>  |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12035

|  |  |   |   |  |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>David A. Dennis                            |   |   |  |  | 2. Date of Death<br>Month Day Year<br>April 1, 1999  |  | 3. Time of Death<br>7:00 AM                                    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>14109 Castaway Drive |   |   |  |  | 4b. City, Town, or Location of Death<br>Rockville  |  | 4c. County of Death<br>Montgomery                              |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-30-0450   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>65 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Sept. 29, 1933  |  | 9. Birthplace (State or Foreign Country)<br>Maryland |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Rockville   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>14109 Castaway Drive   |  |   |   | 10f. Zip Code<br>20853   |  | 10g. Citizen of What Country?<br>United States   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Korean Conflict |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Captain   |  |  | 16b. Kind of Business/Industry<br>Fire Department  |  |  |
| 17. Father's Name (First, Middle, Last)<br>David L. Dennis   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Frances Cornwell  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Irmgard Dennis/Wife  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14109 Castaway Drive, Rockville, Maryland 20853 |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |  |  | Date<br>April 3, 1999  |  | 20c. Location - City or Town, State<br>Silver Spring, Maryland |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>Rockville, Inc., 300 West Montgomery Avenue,<br>Rockville, Maryland 20850-2805  |  |  |  |  |  |  |
| 23a. Part I. Underlying disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Pneumonia<br>Due to (or as a consequence of):<br>2 DAYS<br>b. Bronchogenic Carcinoma<br>Due to (or as a consequence of):<br>4 years<br>c. Chronic obstructive Pulmonary Disease<br>Due to (or as a consequence of):<br>12 years<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |  |  |
|  |  |   | 28a. Place of Injury - At home, term, street, factory, office building, etc. (Specify)  |  |  | 28d. Describe how injury occurred  |  |  |  |
|  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   | 29b. Signature and title of certifier<br>   |  |  | 29c. License number<br>024571  |  | 29d. Date signed (Month, Day, Year)<br>April 1, 1999           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Jay Weiner mo 11501 Georgia Ave Wheaton, Md  |  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 02 1999   |  |   | 32. Registrar's Signature<br>   |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12036

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

MARCETTE DESSOURCES

2. Date of Death

MARCH 27, 1999

3. Time of Death

6:43AM

4a. Facility Name (If not institution, give street and number)

1308 MIMOSA LANE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

097-40-1675

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 25, 1936

9. Birthplace (State or Foreign Country)

HAITI

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1308 MIMOSA LANE

10f. Zip Code

20904

10g. Citizen of What Country?

HAITI

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

VICE PRESIDENT/SELF EMPLOYED

16b. Kind of Business/Industry

PRINTING

17. Father's Name (First, Middle, Last)

THELAMON JADOTTE

18. Mother's Name (First, Middle, Maiden Surname)

STEPHANIA BARLATIER

19a. Informant's Name/Relationship (Type, Print)

FRANCK DESSOURCES (SPOUSE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1308 MIMOSA LANE SILVER SPRING, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parc de Tabarre, Freres

Date

3-31-99

20c. Location - City or Town, State

Petion ville, Haiti

21. Signature of Funeral Service Licensee

22. Name and Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE  
AVENUE SILVER SPRING, MARYLAND 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC OVARIAN CARCINOMA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 MONTHS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home

26. Place of Death (Check only one)

5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6410 ROCKLEDGE DRIVE #625 BETHESDA, MD. 20817

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

Diana B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12037

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marjorie Ann McDonald Dorman

2. Date of Death

Month Day Year  
March 31, 1999

3. Time of Death

8:20 pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

220-12-4173

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 25, 1924

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1518 Windham Lane

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Payroll Supervisor

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Ronald Andrew McDonald

18. Mother's Name (First, Middle, Maiden Surname)

Ruth A. Kernodle

19a. Informant's Name/Relationship (Type, Print)

Horton Dorman / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1518 Windham Lane, Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

April 1

1999

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Tracy A. Shuman

22. Name and Address of Facility

Collins Funeral Home  
500 University Blvd W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anoxia, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Carcinoma of the lung

Months

Due to (or as a consequence of):

b. Interstitial lung disease

Years

Due to (or as a consequence of):

c. Pneumonitis

Months

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Hypertension

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert F. Musselman MD

29c. License number

D47215

29d. Date signed (Month, Day, Year)

March 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert F. Musselman, M.D. 10801 Lockwood Drive #200, Silver Spring, MD 20901

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12038

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD R. DONADIO

2. Date of Death

March 28 1999

3. Time of Death

0335

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

056-16-0251

6. Sex

M 2 F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 10, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2713 Fallsmount Dr.

10f. Zip Code

21047

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Maitre'D

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

George Donadio

18. Mother's Name (First, Middle, Maiden Surname)

(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

Edward R. Day / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

77 Sand Road, Fairfield, NJ 07004

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Glendale Cemetery

Date

4/2/99

20c. Location - City or Town, State

Bloomfield, NJ

21. Signature of Funeral Service Licensee

Hilly K. McComas

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Md. 2100923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 HOUR

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Andrew Nowakowski MD

29c. License number

D08096

29d. Date signed (Month, Day, Year)

MARCH 28 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW NOWAKOWSKI MD 125 N. MAIN ST. BELAIR, MD 21014

State  
Registrar

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

B. Spauld

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12039

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMILY ELIZABETH SPARKS DOW

2. Date of Death

March 31, 1999

3. Time of Death

3:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Gilchrist Center for Hospice Care

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

220-30-4903

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

8/7/1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Monkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2936 Sheppard Road

10f. Zip Code

21111

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

College Professor

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Douglas Alan Sparks

18. Mother's Name (First, Middle, Maiden Surname)

Emily Reid Hutchins

19a. Informant's Name/Relationship (Type, Print)

Wallace E. Dow/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation

Date

4/1 1999

20c. Location - City or Town, State

Hampstead, Maryland

21. Signature of Funeral Service Licensee

M. Blacken Ruffin

22. Name and Address of Facility

E.G. Kurtz & Son Funeral Home, P.A.  
Jarrettsville, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. esophageal cancer  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W A Riley

29c. License number

D25205

29d. Date signed (Month, Day, Year)

March 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W A Riley 606 6701 N. Charles St Balto. md

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

B. Sparks

21204

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Elizabeth Dow expired 3/31/99 3pm

Baltimore, Maryland 21215-0020

1950-1-10 10:00 AM

1950-1-10 10:00 AM

1950-1-10 10:00 AM

1950-1-10 10:00 AM

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1950-1-10 10:00 AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AREE ELLA DEFRATES

2. Date of Death

March 20, 1999

3. Time of Death

1:45P

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health of Bel Air

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

216-16-4727

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 22, 1917

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

904 Philadelphia Road

10f. Zip Code

21009

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Hostess

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Benjamin Harrison Eller

18. Mother's Name (First, Middle, Maiden Surname)

Leona Mae Minton

19a. Informant's Name/Relationship (Type, Print)

Flossie E. Edwards - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

904 Philadelphia Road, Abingdon, MD 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bel Air Memorial Grdns. 3/24/99

Date

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Howard K. McComas

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Rd., Abingdon, MD 2100923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. acute exacerbation of COPD

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. upper respiratory infection

Due to (or as a consequence of):

4 days

c. Cigarette smoking

Due to (or as a consequence of):

year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHF, Hypertension, SVT

23b. Did tobacco use contribute to the cause of death?

X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes X No25. Was case referred to medical  
examiner?1 ☐ Yes X No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

NA

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

NA

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

NA

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

NA

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Patricia Dubyoski

29c. License number

D29227

29d. Date signed (Month, Day, Year)

3/24/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PATRICIA DUBYOSKI 665 West McPherson Bel Air MD 21014

31. Date filed (Month, Day, Year)

MAR 23 1999

32. Registrar's Signature

B. Spence

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DeFrates, Aree

Division of Vital Records, P.O. Box 68760,

Handwritten signature and date: 2001 2 3 AM



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12041

|   |  |                                    |  |   |  |   |  |  |
|---|--|------------------------------------|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Jack Joseph Dalton</b>                                |                                    |  |   | 2. Date of Death<br>Month <b>3</b> Day <b>27</b> Year <b>99</b>  |   | 3. Time of Death<br><b>2105</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b> |                                    |  |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>242-22-7969</b>  |                                    | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth (Month, Day, Year)<br><b>March 29, 1924</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b>   |
|   | Usual Residence of Decedent  |                                    |  |   |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b> |  | 10c. City, Town or Location<br><b>Annapolis</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>610 Americana Drive Apt. 104</b>   |  |                                    |  | 10f. Zip Code<br><b>21403</b>   |  | 10g. Citizen of What Country?<br><b>United States</b> |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-46</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> Collage (1-4or 5+) <b></b>  |  |                                    |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>  |  |   | 16b. Kind of Business/Industry<br><b>Elevator</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph C. Dalton</b>  |  |                                    |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elvira Keesler</b>   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert J. Dalton (Son)</b>   |  |                                    |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2010 Huntwood Drive Gambrills, MD 21054</b>  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                    |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery</b>   |  | Date<br><b>4/2/99</b>                                 | 20c. Location - City or Town, State<br><b>Crownsville, Maryland</b>                            |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                    |  |   | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home, Inc.<br/>147 Duke of Gloucester St. Annapolis, MD 21401</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cardiopulmonary Arrest / ASCVD</b><br>Due to (or as a consequence of):<br><b>Electrocardiogram Dissolution (PEA)</b><br>Due to (or as a consequence of):<br><b>Myocardial Infarction (Massive)</b><br>Due to (or as a consequence of):<br><b>Respiratory Arrest / Cardiovascular Dz</b> |  |                                    |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>30 min</b><br><b>1 hr</b><br><b>4 hrs</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiovascular Dz</b><br><b>Tobacco use &gt; 40 px</b>   |  |                                    |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                    |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |                                    |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |                                    |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                    |  | 28d. Describe how injury occurred   |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                    |  |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                    |  | 29b. Signature and title of certifier<br><b>Christopher M. Grands</b>   |  | 29c. License number<br><b>D0035050</b>                |  | 29d. Date signed (Month, Day, Year)<br><b>3/27/99</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PO Box 4826 Baltimore MD 21211</b>   |  |                                    |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  |                                    |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

222 E. J. S. Walker



Amended #22, Md.  
3/29/99, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12042

|   |  |   |  |  |   |   |   |  |   |  |
|---|--|---|--|--|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Harold Devon Diehl</u>                          |   |  |  | 2. Date of Death<br>Month <u>March</u> Day <u>28</u> Year <u>1999</u> |   |   |  | 3. Time of Death<br><u>9:21 AM</u>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Sacred Heart Hospital</u> |   |  |  | 4b. City, Town, or Location of Death<br><u>Cumberland</u>             |   |   |  | 4c. County of Death<br><u>Allegany</u>                      |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>219-14-5768</u>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><u>74</u> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><u>April 2, 1924</u> |  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u> |  |
|   | Usual Residence of Decedent  |   |  |  |   |   |   |  |   |  |
| 10a. State<br><u>Pennsylvania</u>   |  | 10b. County<br><u>SOMERSET</u>  |  | 10c. City, Town or Location<br><u>Wellersburg</u>  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><u>ROUTE 160 PO BOX 36</u>  |  | 10f. Zip Code<br><u>15564</u>   |  |  |   | 10g. Citizen of What Country?<br><u>United States</u> |   |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>9</u> College (1-4or 5+) <u></u>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Crane Operator</u>                |  |  |   | 16b. Kind of Business/Industry<br><u>Railroad</u>     |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><u>John Frank Diehl</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Lula Ann (Michaels) Diehl</u>  |   |   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Mary Susan Diehl Wife</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>PO Box 36 Wellersburg, Pennsylvania 15564</u>  |   |   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Restlawn Memorial Gardens</u>  |  |  |   | Date<br><u>March 31, 1999</u>                         |   | 20c. Location - City or Town, State<br><u>Cumberland, Maryland</u>                             |   |  |
| 21. Signature of Funeral Service Licensee<br><u>Douglas S. Pettigrew</u>  |  |   |  | 22. Name and Address of Facility<br><u>Harvey H. Zeigler Funeral Home Hyndman, Pennsylvania</u>  |   |   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>MYOCARDIAL INFARCTION</u><br>Due to (or as a consequence of):<br>b. <u>CORONARY ARTERY DISEASE</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><br>27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br><br>28a. Date of Injury (Month, Day, Year)<br>28b. Time of injury<br>M <input type="checkbox"/> AM <input type="checkbox"/> PM<br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br><br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><br>29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><br>29b. Signature and title of certifier<br><u>[Signature] MD</u><br>29c. License number<br><u>DJ0931</u><br>29d. Date signed (Month, Day, Year)<br><u>MARCH 28, 1999</u><br><br>30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>VIRGINIA C. MARCHAND, MD 912 PETON DRIVE CUMBERLAND, MD 21022</u><br><br>31. Date filed (Month, Day, Year)<br><u>MAR 29 1999</u><br>32. Registrar's Signature<br><u>[Signature]</u> |  |   |  |  |   |   |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Amede 5, M.D.,  
4/2/99, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12043

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD LEE DEREMER

2. Date of Death  
Month Day Year  
March 28 1999

3. Time of Death  
15:24

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

213-24-5665

6. Sex

1X M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 16, 1929

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

WV

10b. County

MINERAL

10c. City, Town or Location

FORT ASHBY

10d. Inside City Limits

1 ☐ Yes 2X ☒ No

10e. Street and Number

ROUTE 2, BOX 370

10f. Zip Code

26719

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1X ☒ Navar Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2X ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FARMER

16b. Kind of Business/Industry

FARMING

17. Father's Name (First, Middle, Last)

CHARLES DEREMER

18. Mother's Name (First, Middle, Maiden Surname)

SARAH E. DANIELS

19a. Informant's Name/Relationship (Type, Print)

HERBERT DEREMER / BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7713 ERIE STREET, ANNANDALE, VA 22003

20a. Method of Disposition

1X ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT ASHBY CEMETERY

Date

4/1/99

20c. Location - City or Town, State

FORT ASHBY, WV

21. Signature of Funeral Service Licensee

Herbert A. Upchurch

22. Name and Address of Facility

UPCHURCH FUNERALHOME, INC.  
P.O. BOX 1260, FORT ASHBY, WV 26719

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple System Failure with 3 hrs  
Due to (or as a consequence of):  
b. Chronic lung disease and 30 yrs  
Due to (or as a consequence of):  
c. Cirrhosis of liver 40 yrs  
Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4X ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2X ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2X ☒ No

Hospital:

1 ☐ Inpatient

2X ☒ Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1X ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Guy Fiscus

29c. License number

D12779

29d. Date signed (Month, Day, Year)

4/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Guy Fiscus, M.D. - 500 MEMORIAL AVE., CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

DEREMER, CIRHCARD L 235 60 3318

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Handwritten signature or name, possibly "John J. ...".

Handwritten text, mostly illegible due to fading. Some words like "The" and "and" are visible.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12044

|  |   |  |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DONALD F DALTON</b>                                      |  |  |  | 2. Date of Death<br>Month Day Year<br><b>Mar 20 1999</b> |  | 3. Time of Death<br><b>905 AM</b>                          |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  | 4c. County of Death<br><b>Howard</b>                       |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>077-18-4457</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.         |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 5, 1924</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Canada</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Howard</b>                             |  | 10c. City, Town or Location<br><b>Ellicott City</b>        |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3913 Macalpine Road</b>   |  | 10f. Zip Code<br><b>21042</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-65</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Hospital Administrator</b>   |  | 16b. Kind of Business/Industry<br><b>Healthcare</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>William Frank Dalton</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minnie Penfold</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Nancy W. Dalton/Wife</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3913 Macalpine Road Ellicott City, MD 21042</b>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  | 20c. Location - City or Town, State<br><b>3-22-99 Catonsville, MD</b>      |  |
| 21. Signature of Funeral Service Licensee<br><b>Sharon A. Gellins-Witzke</b>   |   | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD 21043</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Malignant Ventricular Arrhythmia</b><br>Due to (or as a consequence of):<br><b>b. Myocardial Ischemia</b><br>Due to (or as a consequence of):<br><b>c. Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>seconds</b><br><b>min</b><br><b>years</b>   |  |  |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>March 20, 1999</b>  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Patrice A. Toney MD ME</b>   |  | 29c. License number<br><b>D 31473</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 21, 1999</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PATRICE A. TONEY, MD 4505 Hemlock Lane Way Ellicott City MD 21042</b>   |   | 31. Date filed (Month, Day, Year)<br><b>MAR 22 1999</b>  |  | 32. Registrar's Signature<br><b>Patrice A. Toney</b>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12045

|   |  |                           |   |  |  |  |   |  |  |  |
|---|--|---------------------------|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>ESTHER E. EVANS                                |                           |   |  |  |  | 2. Date of Death<br>Month Day Year<br>MARCH 29, 1999  |  | 3. Time of Death<br>8:00 A.M.                            |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE NURSING HOME |                           |   |  |  |  | 4b. City, Town, or Location of Death<br>ROCKVILLE   |  | 4c. County of Death<br>MONTGOMERY                        |  |
| Funeral<br>Director   | 5. Social Security Number<br>160-09-7943   |                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>98 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>MARCH 3, 1901  |  | 9. Birthplace (State or Foreign Country)<br>PENNSYLVANIA |  |
|   | Usual Residence of Decedent  |                           |   |  |  |  |   |  |  |  |
| 10a. State<br>MARYLAND  |  | 10b. County<br>MONTGOMERY |   | 10c. City, Town or Location<br>BETHESDA  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 10e. Street and Number<br>7420 WESTLAKE TERRACE, # 702  |  |                           |   |  |  | 10f. Zip Code<br>20817   |   | 10g. Citizen of What Country?<br>U. S. A.  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>4 YEARS  |  |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER |  |  | 16b. Kind of Business/Industry<br>OWN HOME  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>FRANK EGENDORF   |  |                           |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>KATIE FELDMAN   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>ELLIS EVANS (SON)   |  |                           |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7420 WEST LAKE TERRACE APRT #702 BETHESDA |   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MOUNT COMFORT CREMATORY   |  |  | Date<br>3/30/1999  |   | 20c. Location - City or Town, State<br>ALEXANDRIA, VIRGINIA  |  |  |
| 21. Signature of Funeral Service Licensee<br>Donald C. Stettin  |  |                           |   |  |  | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPEL INC. 1170 ROCKVILLE PIKE ROCKVILLE MD                               |   |  |  |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>ATHEROSCLEROSIS</u><br>Due to (or as a consequence of):<br>b. <u>PESONEAL NERVE PALSY</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                           |   |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                           |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |  |                           |   |  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|   |  |                           |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |                           | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                        |  |
|   |  |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                    |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                           | 29b. Signature and title of certifier<br>Swaroop G. Rao   |  |  |  | 29c. License number<br>D 35792  |  | 29d. Date signed (Month, Day, Year)<br>March 29, 1999    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Swaroop G. Rao, M. D., Ph.D 50 W. Edmonston Drive, # 504, Rockville, Md. 20852  |  |                           |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 30 1999  |  |                           | 32. Registrar's Signature<br>B. Sparks  |  |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27 PER MEO G770 4-15-99 WR.

## Certificate of Death

Reg. No.

99 12046

|   |  |   |  |  |   |  |  |  |  |
|---|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Kacy Lauren Edwards                              |   |  |  | 2. Date of Death<br>Month Day Year<br>April 04, 1999      |  | 3. Time of Death<br>7:04 A.M.                            |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Southern Maryland Hospital |   |  |  | 4b. City, Town, or Location of Death<br>Clinton           |  | 4c. County of Death<br>Prince George's                   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-53-9194   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>Yrs. Months Days<br>1 9 |  | 8. Date of Birth (Month, Day, Year)<br>February 23, 1999 |  |  |
|   | 9. Birthplace (State or Foreign Country)<br>LaPlata  |   | 10a. State<br>Maryland   |  | 10b. County<br>Charles                                    |  | 10c. City, Town or Location<br>Waldorf                   |  |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>3269 West Dale Court   |   | 10f. Zip Code<br>20601   |  | 10g. Citizen of What Country?<br>United States                               |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>N/A  |  | 16b. Kind of Business/Industry<br>N/A  |   | 17. Father's Name (First, Middle, Last)<br>Michael Wayne Edwards   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jennifer Kathleen Lewis |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Michael W. Edwards, Father  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3269 West Dale Court, Waldorf, Maryland 20601  |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory   |  | 20c. Location - City or Town, State<br>Alexandria, Virginia                  |  |
| 21. Signature of Funeral Service Licensee<br>Edward N. Brinsfield, Jr. M00052   |  | 22. Name and Address of Facility<br>Brinsfield Funeral Home, P.A.<br>22955 Hollywood Road, Leonardtown, MD 20650  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>SUDEN INFANT DEATH SYNDROME<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |   | Approximate Interval Between Onset and Death   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>Dennis J. Chute, MD  |  | 29c. License number<br>O.C.M.E.  |   | 29d. Date signed (Month, Day, Year)<br>April 05, 1999  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute, MD   |  | 31. Date filed (Month, Day, Year)<br>APR 09 1999  |  | 32. Registrar's Signature<br>Dennis J. Chute   |   | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>111 Penn Street, Baltimore, Maryland 21201                     |  |  |  |

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12047

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Elma (NMN) Edison

2. Date of Death

March 30 1999

Day

Year

3. Time of Death

10:56 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

255-01-8349

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 18, 1910

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2235 Erin Way

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Flavius Napoleon Cox

18. Mother's Name (First, Middle, Maiden Surname)

Annette (NMN) Mims

19a. Informant's Name/Relationship (Type, Print)

M. Joyce Litz/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2235 Erin Way, Bel Air, MD 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

4/2/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Howard K. McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease, Dementia

Coronary Artery Disease

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D0051356

29d. Date signed (Month, Day, Year)

March 30, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Picco MD 9000 Franklin Square Drive Baltimore Maryland 21237

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

[Signature]

State  
RegistrarEdison, Elma  
Baltimore, Maryland 21215-0020

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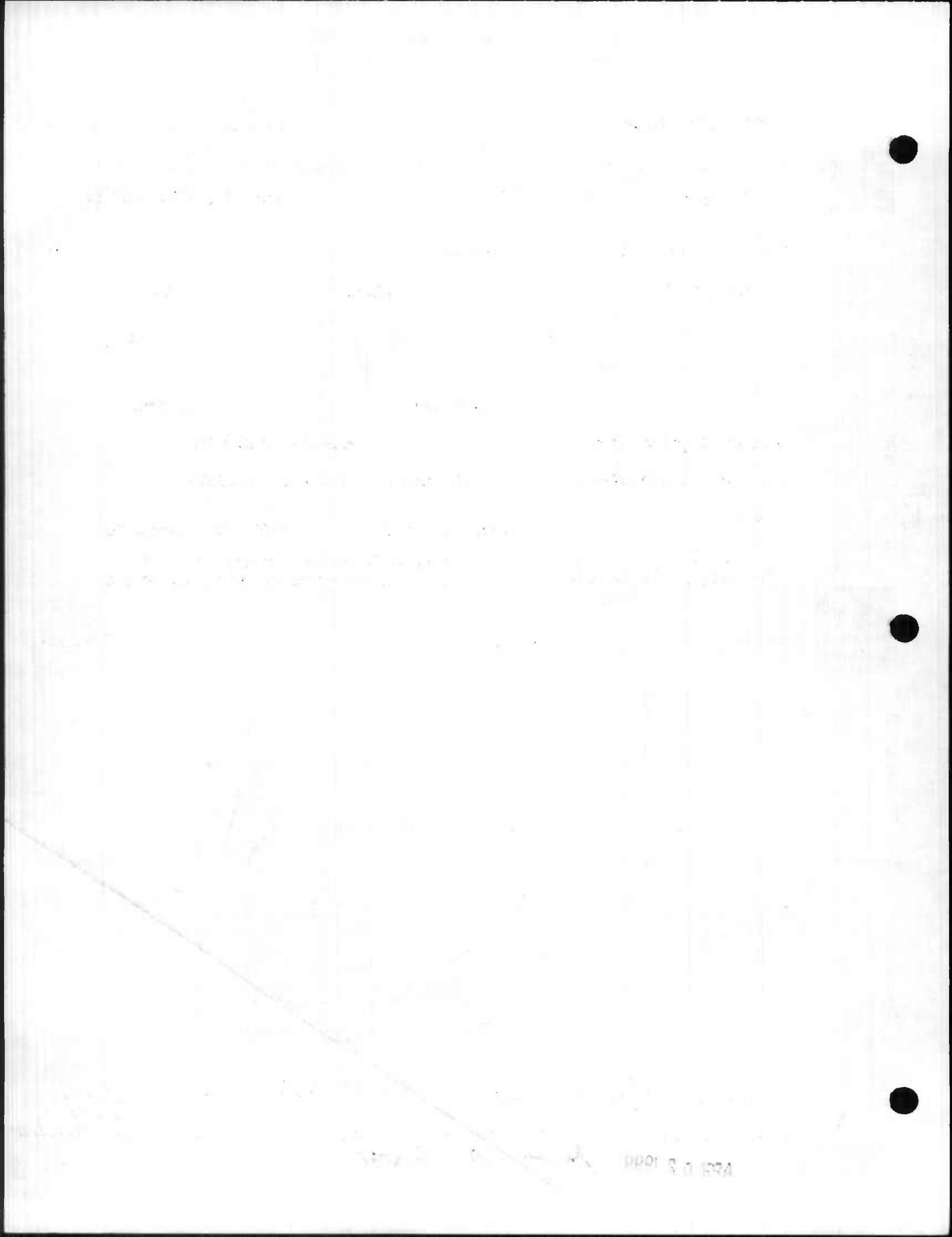
Physician  
/Medical  
Examiner

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State of Maryland / Department of Health and Mental Hygiene

99-12048

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |  |  |
|--|---|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>ELIZABETH N. EAKENS   |  |   |  |  | 2. Date of Death<br>Month Day Year<br>MARCH 31, 1999   |   |  | 3. Time of Death<br>5:45AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>GINGER COVE HEALTH CARE   |  |   |  |  | 4b. City, Town, or Location of Death<br>ANNAPOLIS  |   |  | 4c. County of Death<br>ANNE ARUNDEL  |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-18-5484  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>82 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>OCT. 30, 1916  |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  |
|  | Usual Residence of Decedent   |  |   |  |  | 10a. State<br>MARYLAND   |   | 10b. County<br>ANNE ARUNDEL                                      |  | 10c. City, Town or Location<br>ANNAPOLIS |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br>4000 RIVER CRESCENT DRIVE   |  |   |  |  | 10f. Zip Code<br>21401   |   | 10g. Citizen of What Country?<br>UNITED STATES                   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) 4  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER  |  |  | 16b. Kind of Business/Industry<br>HOME   |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>WALTER BLAKE NORRIS  |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>FRANCES HOLLYDAY  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>JANE DERBY (DAUGHTER)   |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2535 RIVER ROCK DRIVE MACUNGIE, PA. 18062 |   |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ST. ANNES CEMETERY  |  | Date<br>04-05-99   |  | 20c. Location - City or Town, State<br>ANNAPOLIS, MARYLAND                                      |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  |  | 22. Name and Address of Facility<br>JOHN M. TAYLOR FUNERAL HOME, INC.<br>147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD. 21401                   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. SEPSIS<br>Due to (or as a consequence of):<br>b. Colonic-cutaneous fistula<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br>1 wk<br>1 mo   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |   |  |   |  |  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                    |  |  |  |
|  | 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner   |  | 29b. Signature and title of certifier<br>  |  |  |  |   |  |  |  |
|  |   |  | 29c. License number<br>D3076  |  | 29d. Date signed (Month, Day, Year)<br>3-31-99   |  |   |  |  |  |
| State<br>Registrar   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>John Jacobson MD, 2003 Ford Pkwy #100, Annapolis, MD 21401  |  |   |  |  |  |   |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>APR 01 1999  |  | 32. Registrar's Signature<br>   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12049

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|--|--|--|---------------------------------|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ronald Lee Emerick, Jr.</b>                                 |  |                                 |  |  |  | 2. Date of Death<br>Month Day Year<br><b>March 22, 1999</b> |  | 3. Time of Death<br><b>8:30 P.M.</b>                        |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>University Hospital, Shock Trauma</b> |  |                                 |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>    |  | 4c. County of Death<br><b>N/A</b>                           |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>168-56-6998</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F |  | 7. Age (In yrs. last birthday)<br><b>28</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>May 27, 1970</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Usual Residence of Decedent  |  |                                 |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10a. State<br><b>Pennsylvania</b>  |  |  |                                 |  |  |  |   |  |   | 10b. County<br><b>Bedford</b>  |  |  |  |  |  |  |  |  |  | 10c. City, Town or Location<br><b>Hyndman</b>   |  |  |  |  |  |  |  |  |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10e. Street and Number<br><b>179 West Furnace Street</b>   |  |  |                                 |  |  |  |   |  |   | 10f. Zip Code<br><b>15545</b>  |  |  |  |  |  |  |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  |  |                                 |  |  |  |   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |  |  |  |  |  |  |  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  |  |  |  |  |  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  |  |                                 |  |  |  |   |  |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |  |  |  |  |  |  |  |  |  | 16b. Kind of Business/Industry<br><b>Masonry</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ronald Lee Emerick, Sr.</b>  |  |  |                                 |  |  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Karen (Blubaugh) Emerick</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Karen Emerick -- Mother</b>   |  |  |                                 |  |  |  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>179 West Furnace Street Hyndman, Pennsylvania 15545</b>                      |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  |  |                                 |  |  |  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Comps Cemetery</b>  |  |  |  |  |  |  |  |  |  | 20c. Location - City or Town, State<br><b>Hyndman, Pennsylvania</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Harvey H. Zeigler</b>  |  |  |                                 |  |  |  |   |  |   | 22. Name and Address of Facility<br><b>Harvey H. Zeigler Funeral Home 169 Clarence Street Hyndman, Pennsylvania</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Multiple Myeloma</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |                                 |  |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown<br><b>4</b>  |  |  |  |  |  |  |  |  |  | 24e. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No<br><b>1</b>  |  |  |  |  |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No<br><b>1</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  |  |                                 |  |  |  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  |  |                                 |  |  |  |   |  |   | 28a. Date of Injury (Month, Day, Year)<br><b>3/2/99</b>  |  |  |  |  |  |  |  |  |  | 28b. Time of Injury<br><b>Unknown</b> M   |  |  |  |  |  |  |  |  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No<br><b>2</b>  |  |  |  |  |  |  |  |  |  | 28d. Describe how injury occurred<br><b>Subject drove vehicle that struck tree</b> |  |  |  |  |  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Route 1 Hyndman, Pennsylvania</b> |  |  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |                                 |  |  |  |   |  |   | 29b. Signature and title of certifier<br><b>Theresa M. Higgins</b>   |  |  |  |  |  |  |  |  |  | 29c. License number<br><b>O.C.M.E.</b>  |  |  |  |  |  |  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>March 24, 1999</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>THEOPHILE MURKIN</b>  |  |  |                                 |  |  |  |   |  |   | 31. Date filed (Month, Day, Year)<br><b>MAR 25 1999</b>  |  |  |  |  |  |  |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12050

|   |  |                              |  |  |   |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
|---|--|------------------------------|--|--|---|--|--|--|--------------------------------------|---|----|-------------------------|---|----|----------------------------|--------------------|----|---------------------|--------------|----|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ferne S. Evans</b>  |                              |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> Year <b>1999</b>   |  |  |  | 3. Time of Death<br><b>10:40 pm</b>  |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Agnes Nursing And Rehabilitation Center</b> |                              |  |  | 4b. City, Town, or Location of Death<br><b>Ellicott City</b>  |  |  |  | 4c. County of Death<br><b>Howard</b> |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>356-10-3901</b>  |                              | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Jan 23, 1920</b>               |  | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>    |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
|   | Usual Residence of Decedent  |                              |  |  |   |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Howard</b> |  | 10c. City, Town or Location<br><b>Columbia</b>   |   |  |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                   |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 10e. Street and Number<br><b>9511 Good Lion Road</b>  |  |                              |  | 10f. Zip Code<br><b>21045</b>  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  |                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b>     |  |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b> |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |                              |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired)<br><b>Manager</b>                          |   |  | 16b. Kind of Business/Industry<br><b>Government</b>  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Satterwhite</b>  |  |                              |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Pricer</b>  |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John Michael Phillips/Son</b>  |  |                              |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9511 Good Lion Road Columbia, Maryland 21045</b> |   |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  |                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. View Cemetery</b> |  |   | 20c. Location - City or Town, State<br><b>3-15-99 Marriottsville, MD</b> |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Shawn A. Collins-Witzke</b>   |  |                              |  |  | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b> |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                              |  |  |   |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| <table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td><b>BRONCHOPNEUMONIA</b></td> <td>Approximate Interval Between Onset and Death<br/><b>One week</b></td> </tr> <tr> <td>b.</td> <td><b>CEREBRAL HEMORRHAGE</b></td> <td><b>Three weeks</b></td> </tr> <tr> <td>c.</td> <td><b>HYPERTENSION</b></td> <td><b>Years</b></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |  |                              |  |  |   |  |  |  |                                      | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>BRONCHOPNEUMONIA</b> | Approximate Interval Between Onset and Death<br><b>One week</b> | b. | <b>CEREBRAL HEMORRHAGE</b> | <b>Three weeks</b> | c. | <b>HYPERTENSION</b> | <b>Years</b> | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.   | <b>BRONCHOPNEUMONIA</b>      | Approximate Interval Between Onset and Death<br><b>One week</b>                                    |  |   |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
|   | b.   | <b>CEREBRAL HEMORRHAGE</b>   | <b>Three weeks</b>   |  |   |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
|   | c.   | <b>HYPERTENSION</b>          | <b>Years</b>   |  |   |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
|   | d.   |                              |  |  |   |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Senile Dementia</b>  |  |                              |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  |                              |  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |  |                              | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |  | 28d. Describe how injury occurred    |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>  |  |                              | 29b. Signature and title of certifier<br><b>Dr. B. Vellanki</b>                                    |  |   | 29c. License number<br><b>D-30469</b>                                    |  | 29d. Date signed (Month, Day, Year)<br><b>March 13, 1999</b>   |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N.B. VELLANKI, MD, 9055 CHEVROLET DRIVE, # suite 100, ELICOTT CITY : MD 21042</b>  |  |                              |  |  |   |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 1999</b>   |  |                              | 32. Registrar's Signature<br><b>B. Sparks</b>  |  |   |  |  |  |                                      |   |    |                         |   |    |                            |                    |    |                     |              |    |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

ITEM: #2 PER MD G770 4-21-99 WR.

09 12051

|  |  |                           |   |   |  |   |  |  |  |  |  |
|--|--|---------------------------|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Rosalie Elisa Finch                                  |                           |   |   |  |   | 2. Date of Death<br>Month: MARCH 28<br>Day: March 29, 1999<br>Year: 1999 |  | 3. Time of Death<br>5:45 PM                                |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Mariner Health of Circle Manor |                           |   |   |  |   | 4b. City, Town, or Location of Death<br>Kensington                       |  | 4c. County of Death<br>Montgomery                          |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>093-14-6178   |                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>99 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Aug. 6, 1899                      |  | 9. Birthplace (State or Foreign Country)<br>Virgin Islands |  |  |
|  | Usual Residence of Decedent  |                           |   |   |  |   |  |  |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Montgomery |   | 10c. City, Town or Location<br>Kensington   |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br>10231 Carroll Place  |  |                           |   | 10f. Zip Code<br>20895  |  |   |  | 10g. Citizen of What Country?<br>United States   |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12  |  |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housekeeper  |  |   |  | 16b. Kind of Business/Industry<br>Hotel  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Alexander Finch   |  |                           |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emmeline Irwin   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Hilvan J. Finch (nephew)   |  |                           |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3311 Lockwood Court, Lilburn, GA 30047 |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  | Date<br>4-2-99  |  | 20c. Location - City or Town, State<br>Beltsville, Maryland  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                           |   |   |  | 22. Name and Address of Facility<br>Rapp Funeral Services, P.A.<br>933 Gist Avenue, Silver Spring, Maryland 20910                       |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Atherosclerotic Coronary Bascular Disease<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |                           |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Alzheimer's Dementia   |  |                           |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                           |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                           |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |                           |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred            |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                           |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                           |   |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |                           |   |   |  | 29c. License number<br>D 34032  |  | 29d. Date signed (Month, Day, Year)<br>March 29, 1999  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Jeanne P. Asher, M. D., 3720 Farragut Avenue, Kensington, MD 20895   |  |                           |   |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 31 1999   |  |                           |   | 32. Registrar's Signature<br>   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12052

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |  |   |
|---|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Louise Ann Fornili</b>                 |   |  |  | 2. Date of Death<br>Month Day Year<br><b>March 25, 1999</b>                   |  | 3. Time of Death<br><b>5:15 PM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Andrus House</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>                       |  | 4c. County of Death<br><b>Montgomery</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-58-6885</b>                                       |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>100</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>June 7, 1898</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Michigan</b>   |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br><b>Md</b>   |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Potomac</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>8740 Sleepy Hollow Lane</b>  |   |   |  | 10f. Zip Code<br><b>20854</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |   |  | 16b. Kind of Business/Industry<br><b>Education</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Holihan</b>   |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gertrude Schiffer</b> |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Judith A. Pauley/Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8740 Sleepy Hollow Lane, Potomac, Maryland 20854</b>                                     |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Silver Spring, MD.</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Curtis E. Day</b>   |   |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home<br/>10 East Deer Park Dr., Gaithersburg, MD. 20877</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><b>BREAST CANCER</b><br>Due to (or as a consequence of):<br><b>SENILE DEMENTIA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>IMMEDIATE</b><br><br><b>5 YEARS</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br><b>Margaret Marie Thompson</b>   |  | 29c. License number<br><b>D44025</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 26, 1999</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. Linda Thompson, M.D., 11125 Rockville Pike, # 103, Rockville, MD. 20852</b>   |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |   | 32. Registrar's Signature<br><b>Renata B. Sparks</b>  |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 26a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12053

Certificate of Death

Reg. No.

|  |   |  |  |   |   |  |   |  |
|--|---|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ESTELLE M. FARRELL</b>                               |  |  |   | 2. Date of Death<br>Month <b>3</b> Day <b>30</b> Year <b>99</b> |  | 3. Time of Death<br><b>03:15 PM</b>                         |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Clinton</b>          |  | 4c. County of Death<br><b>Prince George</b>                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-66-9626</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                |  | 8. Date of Birth (Month, Day, Year)<br><b>June 27, 1917</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>St. Mary</b>                                  |  | 10c. City, Town or Location<br><b>Avenue</b>                |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>22326 Ellis Road</b>  |  | 10f. Zip Code<br><b>20609</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Leo Aloysius Lathroum</b>  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Violet Johnson</b>   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Agnes Marie Hayden</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>41449 Helen Court, Leonardtown, MD 20650</b>  |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>April 5, 1999 Bushwood, MD</b>   |  | 21. Signature of Funeral Service Licensee<br><i>Michael L. Gardiner</i>   |   | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home</b><br><b>P.O. Box 270, Leonardtown, Md 20650</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)   |   |  |
| 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>George I. Okans</i>   |   | 29c. License number<br><b>D41248</b>   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>3/30/99</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GEORGE I. OKANS MD SMHC</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 2 1999</b>  |   | 32. Registrar's Signature<br><i>B. Sparks</i>  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12054

|   |   |  |   |                                |  |   |  |  |  |  |
|---|---|--|---|--------------------------------|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Glenn Wesley Farthing   |  |   |                                | 2. Date of Death<br>Month Day Year<br>March 21, 1999   |   |  |  | 3. Time of Death<br>14:15  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Harford Memorial Hospital   |  |   |                                | 4b. City, Town, or Location of Death<br>Havre de Grace   |   |  |  | 4c. County of Death<br>Harford   |  |
| Funeral<br>Director   | 5. Social Security Number<br>236-54-7119  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |                                | 7. Age (In yrs. last birthday)<br>63 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Jan. 26, 1936       |  | 9. Birthplace (State or Foreign Country)<br>West Virginia  |  |
|   | Usual Residence of Decedent   |  |   |                                |  |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |  | 10b. County<br>Harford  |                                | 10c. City, Town or Location<br>Edgewood  |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>2418 Hanson Road  |  |   |                                | 10f. Zip Code<br>21040   |   | 10g. Citizen of What Country?                              |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1953-57 |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+)  |  |   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Auto Worker   |   |  |  | 16b. Kind of Business/Industry<br>Auto Manufacturer  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Robert Brown Farthing  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Vada (nmn) Robinson   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Margaret J. Bowman/ Sister  |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3321 Willoughby Beach Road, Edgewood, MD 21040  |   |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Crest Lawn Memorial Grdn  |                                | Date<br>3-26-99  |   | 20c. Location - City or Town, State<br>Baltimore, Maryland |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Howard K. McComas  |  |   |                                | 22. Name and Address of Facility<br>Howard K. McComas III Funeral Home, P.A.<br>1317 Cokesbury Road, Abingdon, Maryland 21009  |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |  |   |                                |  |   |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |                                |  |   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |                                |  |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |                                |  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |                                |  |   |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |   |                                |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)                  |   | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                                |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>Kopshane M.D. |   | 29c. License number<br>D 31856 |  | 29d. Date signed (Month, Day, Year)<br>MARCH 23, 1999   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>D. SHARMA 1814 BEL AIR RD FALLSTON MD 21047   |   |  |   |                                |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 25 1999  |   | 32. Registrar's Signature<br>B. Spotts                 |   |                                |  |   |  |  |  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12055

Certificate of Death

Reg. No.

|  |  |                                    |   |   |  |                                 |  |  |  |  |
|--|--|------------------------------------|---|---|--|---------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Eleanor Mary Filloramo</b>                            |                                    |   |   | 2. Date of Death<br>Month <b>03</b> Day <b>28</b> Year <b>1999</b>   |                                 |  |  | 3. Time of Death<br><b>0250 PM</b>                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Crofton Convalescent Center</b> |                                    |   |   | 4b. City, Town, or Location of Death<br><b>Crofton</b>   |                                 |  |  | 4c. County of Death<br><b>Anne Arundel</b>               |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578 42 4525</b>  |                                    | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br><b>84</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>10/18/1914</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Italy</b> |  |
|  | Usual Residence of Decedent  |                                    |   |   |  |                                 |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b> |   | 10c. City, Town or Location<br><b>Mayo</b>  |  |                                 |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>PO BOX 753</b>  |  |                                    |   | 10f. Zip Code<br><b>21106</b>   |  |                                 |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |                                    |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |                                 |  | 16b. Kind of Business/Industry<br><b>Own home</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Not available</b>  |  |                                    |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Not available</b>  |                                 |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rose Filloramo (granddaughter)</b>  |  |                                    |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Box 753, Mayo MD 21106</b>   |                                 |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                    |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft Lincoln Cemetery</b>  |  | Date<br><b>3/31/99</b>          |  | 20c. Location - City or Town, State<br><b>Brentwood MD</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                                    |   |   | 22. Name and Address of Facility<br><b>Advent Funeral &amp; Cremation Services<br/>Annapolis MD 21401</b>  |                                 |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. End Stage Parkinson's Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. 10 year</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |                                    |   |   |  |                                 |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                    |   |   |  |                                 |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |  |                                    |   |   |  |                                 |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |  |                                    |   |   |  |                                 |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                    |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |                                    |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |  |                                    |   | 28d. Describe how Injury occurred   |  |                                 |  |  |  |  |
|  |  |                                    |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 |  |  |  |  |
|  |  |                                    |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                 |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |                                    |   |   |  |                                 |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |                                    |   |   | 29c. License number<br><b>D 22028</b>  |                                 |  | 29d. Date signed (Month, Day, Year)<br><b>3 28 99</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul Rhodes, MD<br/>1667 Crofton Centre Crofton Md 21114</b>  |  |                                    |   |   |  |                                 |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>  |  |                                    |   | 32. Registrar's Signature<br>   |  |                                 |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend. 17,20a,22 3/30/99 SM AACO Health

Certificate of Death

Reg. No.

99 12056

|  |  |   |  |   |   |  |  |  |
|--|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>James M. Fransen</b>                                  |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>28</b> Year <b>1999</b> |  | 3. Time of Death<br><b>12:00 pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>              |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>446-26-6810</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb 23, 1927</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Oklahoma</b>                      |
|  | Usual Residence of Decedent  |   |  |   |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Severna Park</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>600 McKinsey Park Drive</b>   |  |   |  | 10f. Zip Code<br><b>21146</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>5+</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Doctor of Genetics</b>  |   |  | 16b. Kind of Business/Industry<br><b>Research</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry W. <del>Fransen</del> Fransen</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Tena Merk</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Harvey Fransen / brother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2411 Sunup Drive, Clinton, MD 73601</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Clinton Cemetery</b>   |   | Date <b>Apr 3 1999</b>   |  | 20c. Location - City or Town, State<br><b>Clinton, Oklahoma</b>                  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Sons<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Subdural Hematoma</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Depression</b><br>Due to (or as a consequence of):<br><b>c. Alcohol abuse</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>3 Day</b>                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Depression</b><br><b>Alcohol abuse</b>  |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D47518</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3-28-99</b>                            |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Theresa Buck MD Anne Franklin + Cathedral St Annapolis, MD 21401.</b>   |  |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |  |   |  | 32. Registrar's Signature<br>   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12057

Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |  |  |
|---|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CYNTHIA V. FORD</b>                                     |  |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 24, 1999</b> |  | 3. Time of Death<br><b>4:55 PM</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MERCY HOSPITAL (STELLA MARIS)</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>    |  | 4c. County of Death<br><b>NONE</b>                         |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-58-4178</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (in yrs. last birthday)<br><b>45</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 26 1953</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b>                          |  | 10c. City, Town or Location<br><b>SEVERN</b>               |  |
| Usual Residence of Decedent   |  |  |  |  |   |  |  |  |
| 10a. State<br><b>MARYLAND</b>   |  |  | 10b. County<br><b>ANNE ARUNDEL</b>   |  |   | 10c. City, Town or Location<br><b>SEVERN</b>   |  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  | 10e. Street and Number<br><b>1681 CIRCLE RD. APT. 387</b>  |  |   | 10f. Zip Code<br><b>21144</b>  |  |  |
| 10g. Citizen of What Country?<br><b>US</b>  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>2 yrs.</b>           |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>WAREHOUSE WORKER</b>  |  |  | 16b. Kind of Business/Industry<br><b>LOGOTEL COMPANY</b>   |  |   | 17. Father's Name (First, Middle, Last)<br><b>MERRIL DORSEY SR.</b>  |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HARRIETT ELDRIDGE</b>   |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>HARRIETT LEE (MOTHER)</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>701 GLENWOOD ST. APT. 606 ANNAPOLIS, MD. 21401</b> |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WILSON MEM. CEMETERY</b>  |  |   | 20c. Location - City or Town, State<br><b>3/30/99 GAMBRILLS, MD.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Harry D. Reese</b>  |  |  | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>   |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>4 months</b> |  |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>STELLA MARIS AT MERCY HOSPICE</b>  |  |  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  |  |   |  |  |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>M</b>  |  |  |  |  |   |  |  |  |
| 28b. Time of Injury<br><b>M</b>   |  |  |  |  |   |  |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |   |  |  |  |
| 28d. Describe how injury occurred   |  |  |  |  |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Dr. [Signature]</b>   |  |  |  |  |   |  |  |  |
| 29c. License number<br><b>D40854</b>  |  |  |  |  |   |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>MARCH 24, 1999</b>  |  |  |  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DAVID RISEBERG 301 ST PAUL PI BALTIMORE, MD 21202</b>  |  |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |  |  |  |  |   |  |  |  |
| 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12058

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT LEE FRANCE</b>   |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>29</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>4:00 AM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>111 S. CAMDEN AVE.</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>FRUITLAND</b>  |  | 4c. County of Death<br><b>WICOMICO</b>                                  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-32-5119</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 3, 1933</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>WICOMICO</b>  |  | 10c. City, Town or Location<br><b>FRUITLAND</b>                         |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>111 S. CAMDEN AVE.</b>   |  | 10f. Zip Code<br><b>21826</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DRIVER</b>                        |  | 16b. Kind of Business/Industry<br><b>FLORIST</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>RAYMOND FRANCE</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MAE SHORES</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>CHARLOTTE FRANCE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>111 S. CAMDEN AVE. FRUITLAND, MD 21826</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. PAUL'S CEMETERY</b>  |  | Date<br><b>4-1-99</b>   |  | 20c. Location - City or Town, State<br><b>WENONA, MARYLAND</b>          |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804</b>  |  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>COPD.</b><br>Due to (or as a consequence of):  |  |   |  |   |  |   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>weeks</b>   |  |   |  |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |   |  |
|   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred                                       |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
|   | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D 29105</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>                   |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>CHRISTJON HUDDLESTON, M.D. 106 MILFORD ST. SALISBURY, MD 21804</b>  |  |   |  |   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12059

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE F. GARFINKLE

2. Date of Death

03.26.1999

3. Time of Death

6:45 PM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579.28.8288

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11.15.1928

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7420 WESTLAKE TERRACE #1307

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DRYCLEANER

16b. Kind of Business/Industry

DRYCLEANING

17. Father's Name (First, Middle, Last)

HYMAN GARFINKLE

18. Mother's Name (First, Middle, Maiden Surname)

ELLA BASS

19a. Informant's Name/Relationship (Type, Print)

CAROLYN GARFINKLE/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20817  
7420 WESTLAKE TERRACE #1307, BETHESDA, MARYLAND

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS

Date

3.28.99

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

ASPIRATION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

WEEKS

b.

MULTIPLE SCLEROSIS

Due to (or as a consequence of):

40 YEARS

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven Lipson MD

29c. License number

D 05885

29d. Date signed (Month, Day, Year)

03/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN LIPSON 6171 MONTROSE RD, ROCKVILLE

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12060

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Louise Garrett

2. Date of Death

March 30, 1999

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

19310 Club House Road, Apt 102

4b. City, Town, or Location of Death

Montgomery Village

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

448-36-4729

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

December 9, 1911

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

19310 Club House Road, Apt. 102

10f. Zip Code

20886

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Mordecai Galloway Martin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Belle Frazier

19a. Informant's Name/Relationship (Type, Print)

Joseph H. Garrett, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8912 Harness Trail, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rose Hill Burial Park

Date

4-3-99

20c. Location - City or Town, State

Oklahoma City, Oklahoma

21. Signature of Funeral Service Licensee

M00877

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Ave., Rockville, Maryland 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

Minutes

b. Hypertension

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M

29c. License number

D44157

29d. Date signed (Month, Day, Year)

March 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ira Berger, M.D., 809 Veirs Mill Road, #101, Rockville, Maryland 20851

State  
Registrar

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12061  
Certificate of Death

Reg. No.

|   |  |                                  |   |   |   |   |   |  |   |  |
|---|--|----------------------------------|---|---|---|---|---|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Mary H. Gick</b>  |                                  |   |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>27</b> , Year <b>1999</b> |   |  | 3. Time of Death<br><b>5:30 PM</b>                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Collingswood Nursing &amp; Rehabilitation</b> |                                  |   |   |   | 4b. City, Town, or Location of Death<br><b>Rockville</b>                |   |  | 4c. County of Death<br><b>Montgomery</b>              |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>237-22-2417</b>  |                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>June 20 1921</b>                                  |  | 9. Birthplace (State or Foreign Country)<br><b>NC</b> |  |
|   | Usual Residence of Decedent  |                                  |   |   |   |   |   |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b> |   | 10c. City, Town or Location<br><b>Rockville</b> |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>5723 Wainwright Avenue</b>   |  |                                  |   |   | 10f. Zip Code<br><b>20851</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |                                  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alvin Cornelius Hull</b>  |  |                                  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elsie Mae Welch</b>   |   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Eugene E. Gick / Husband</b>   |  |                                  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5723 Wainwright Avenue, Rockville, MD 20851</b>   |   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |   |   | 20c. Location - City or Town, State<br><b>3-30-99 Brentwood, MD</b>     |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                  |   |   | 22. Name and Address of Facility<br><b>Collins Funeral Home<br/>500 University Blvd W., Silver Spring, MD 20901</b>   |   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>30 Min.</b><br><b>20 years</b> |  |                                  |   |   |   |   |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Dementia</b>   |  |                                  |   |   |   |   |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |                                  |   |   |   |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |                                  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                     |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                  |   |   |   |   |   |  |   |  |
| 29b. Signature and title of certifier<br>  |  |                                  |   |   | 29c. License number<br><b>D39934</b>  |   |   | 29d. Date signed (Month, Day, Year)<br><b>March 28, 1999</b>                                   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Steven T. Coulter, M.D. 15201 Shady Grove Road #202, Rockville, Maryland 20850</b>   |  |                                  |   |   |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |  |                                  | 32. Registrar's Signature<br>   |   |   |   |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12062

ITEM: #8 PER F.H. G770 4-21-99 WR.

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Joseph Goldberg

2. Date of Death

Month Day Year  
March 29, 1999

3. Time of Death

6:00 AM

4a. Facility Name (If not Institution, give street and number)

Manor Care Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

051-14-9460

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 4, 1913

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10714 Potomac Tennis Lane

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Structural Engineer

16b. Kind of Business/Industry

Civil Engineering Firm

17. Father's Name (First, Middle, Last)

Hyman Goldberg

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Rose Aginsky

19a. Informant's Name/Relationship (Type, Print)

Ruth Goldberg/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2706 Jennings Road, Kensington, MD 20895

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Memorial Gardens

Date

3/30/99

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

*Reginald V.E.*

22. Name and Address of Facility

Takoma Funeral Home  
254 Carroll St., Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *THROMBOSIA*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *DIABETES*

Due to (or as a consequence of):

c. *PNEUMONIA*

Due to (or as a consequence of):

d. *DEBRIS ULCERS*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

H 51280

29d. Date signed (Month, Day, Year)

3-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anushiravan Dadgar, MD 13219 Executive Park Terrace, Germantown, MD 20894

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12063

|  |  |   |  |   |  |  |  |   |  |  |
|--|--|---|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ALFRED GRIFFIN                             |   |  |   | 2. Date of Death<br>Month Day Year<br>MARCH 26, 1999 |  |  |   | 3. Time of Death<br>11:12PM                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE HOSPITAL |   |  |   | 4b. City, Town, or Location of Death<br>ROCKVILLE    |  |  |   | 4c. County of Death<br>MONTGOMERY                    |  |
| Funeral<br>Director  | 5. Social Security Number<br>329-01-9190   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>78 Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br>APRIL 6, 1920 |   | 9. Birthplace (State or Foreign Country)<br>ILLINOIS |  |
|  | Usual Residence of Decedent  |   |  |   |  |  |  |   |  |  |
| 10a. State   |  | 10b. County   |  | 10c. City, Town or Location<br>WASHINGTON, DC   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 10e. Street and Number<br>103 G. STREET S.W. APT. # 206B   |  |   |  | 10f. Zip Code<br>20004  |  |  |  | 10g. Citizen of What Country?<br>USA  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1945  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>PROFESSOR  |  |  |  | 16b. Kind of Business/Industry<br>EDUCATION   |  |  |
| 17. Father's Name (First, Middle, Last)<br>ZELMA GRIFFIN   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>NORA YOUNG   |  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>HARRY GRIFFIN (BROTHER)  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1130 S. MICHIGAN AVE. #3703 CHICAGO, IL 60605  |  |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>FORT LINCOLN CREMATORY  |  | Date<br>4-2-99  |  | 20c. Location - City or Town, State<br>BRENTWOOD, MARYLAND                           |  |   |  |  |
| 21. Signature of Funeral Service Licensee  |  |   |  | 22. Name and Address of Facility<br>HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904  |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | a. CHRONIC RENAL FAILURE<br>Due to (or as a consequence of):<br>b. CARDIOPULMONARY ARREST<br>Due to (or as a consequence of):<br>c. INSULIN DEPENDENT DIABETES MELLITUS<br>Due to (or as a consequence of):<br>d. |  |  |  | Approximate Interval Between Onset and Death<br>MONTHS  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown          |  |  |  |   |  |  |
|  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                   |  | 29b. Signature and title of certifier<br>Alan R. Segal M.D.   |  |   |  | 29c. License number<br>D52261  |  | 29d. Date signed (Month, Day, Year)<br>MARCH 28, 1999   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ALAN R. SEGAL M.D. 1299 LAMBERTON DR. SILVER SPRING, MD 20902  |  |   |  |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999   |  | 32. Registrar's Signature<br>Geneva B. Sparks   |  |   |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The few requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12064

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>DOROTHEA M. GRIMES   |  |   |  | 2. Date of Death<br>Month Day Year<br>MARCH 29, 1999   |  | 3. Time of Death<br>10:05PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>MONTGOMERY GENERAL HOSPITAL  |  |   |  | 4b. City, Town, or Location of Death<br>OLNEY  |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-68-8353   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>89 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>AUGUST 10, 1909                               |  |
|   | 9. Birthplace (State or Foreign Country)<br>WASHINGTON DC  |  | 10a. State<br>MARYLAND  |  | 10b. County<br>MONTGOMERY  |  | 10c. City, Town or Location<br>SILVER SPRING   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>3511 FOREST EDGE DRIVE  |  | 10f. Zip Code<br>20906   |  | 10g. Citizen of What Country?<br>UNITED STATES                                       |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER  |  | 16b. Kind of Business/Industry<br>HOME   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>AMOS A. ROPER   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARGARET DEWEY  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>DOROTHEA M. GRIMES/ DAUGHTER   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3511 FOREST EDGE DRIVE SILVER SPRING, MD 20906  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>FT. LINCOLN CEMETERY  |  | 20c. Location - City or Town, State<br>04/02/99 BRENTWOOD, MD  |  | 20d. Date  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Anthony S. DiM...</i>  |  |   |  | 22. Name and Address of Facility<br>HINES-RINALDI FUNERAL HOME, INC.<br>11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Ischemic enterocolitis</i><br>Due to (or as a consequence of):<br>b. <i>Acute mesenteric vascular thrombosis</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br>1 day  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |   |  | 29c. License number<br>D05809  |  | 29d. Date signed (Month, Day, Year)<br>3-30-99                                       |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JOHN G. LODMELL, MD. 2901 Olney Rd. Olney MD 20832   |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>APR 01 1999   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12065

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ERNEST E. GRUPE

2. Date of Death  
Month Day Year  
MARCH 27, 19993. Time of Death  
6:30 PM

4a. Facility Name (If not institution, give street and number)

ASBURY METHODIST HOME

4b. City, Town, or Location of Death

GAITHERSBURG

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

094-10-1319

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 30, 1916

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

GAITHERSBURG

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

301 RUSSELL AVE.

10f. Zip Code

20877

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

AUTO DEALER

16b. Kind of Business/Industry

AUTO DEALERSHIP

17. Father's Name (First, Middle, Last)

ERNEST G. GRUPE

18. Mother's Name (First, Middle, Maiden Surname)

EMMA UNKNOWN

19e. Informant's Name/Relationship (Type, Print)

LUCILLE F. GRUPE/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

333 RUSSELL AVE., GAITHERSBURG, MD. 20877

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

3/29/99

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

MO0091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Congestive Heart Failure  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Pulmonary Hypertension  
Due to (or as a consequence of):

months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D33357

29d. Date signed (Month, Day, Year)

3/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee Jonathan Musher 5530 Wisconsin Ave Chevy Chase MD

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12066

|  |   |                                  |   |   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|--|---|----------------------------------|---|---|--|--|---|--|---|---|----|-------------|--|--|----------------------------------|----|-------------------|--|----------------------------------|--|----|--|--|--|----|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Earl Guy Gable                            |                                  |   |   |  |  | 2. Date of Death<br>Month Day Year<br>March 29, 1999    |  | 3. Time of Death<br>6:45 AM                               |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>15350 Tennyson Lane |                                  |   |   |  |  | 4b. City, Town, or Location of Death<br>Scotland        |  | 4c. County of Death<br>St. Mary's                         |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-34-3752  |                                  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>61 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>October 30, 1937 |  | 9. Birthplace (State or Foreign Country)<br>Baltimore, MD |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  | Usual Residence of Decedent   |                                  |   |   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 10a. State<br>Maryland   |   | 10b. County<br>St. Mary's        |   | 10c. City, Town or Location<br>Scotland   |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 10e. Street and Number<br>15350 Tennyson Lane  |   |                                  |   | 10f. Zip Code<br>20687  |  | 10g. Citizen of What Country?<br>United States   |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>1  |   |                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Property Manager   |  |  | 16b. Kind of Business/Industry<br>Realestate            |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br>Earl William Gable  |   |                                  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Hedding  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Paul Tennyson  |   |                                  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15350 Tennyson Lane, Scotland, Maryland 20687 |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                                  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Crestlawn Memorial Gardens  |  | Date<br>4/1/99   |   | 20c. Location - City or Town, State<br>Marriottsville, MD  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br>Edward N. Brinsfield, Jr. M00052  |   |                                  |   |   |  | 22. Name and Address of Facility<br>Brinsfield Funeral Home, P.A.<br>22955 Hollywood Road, Leonardtown, MD 20650                               |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |                                  |   |   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>e.</td> <td>Lung Cancer</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/>1 year</td> </tr> <tr> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>cigarette smoking</td> </tr> <tr> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td></td> <td>c.</td> <td></td> <td></td> </tr> <tr> <td></td> <td>d.</td> <td></td> <td></td> </tr> </table> |   |                                  |   |   |  |  |   |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. | Lung Cancer | Approximate Interval Between Onset and Death<br>1 year |  | Due to (or as a consequence of): | b. | cigarette smoking |  | Due to (or as a consequence of): |  | c. |  |  |  | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | e.  | Lung Cancer                      | Approximate Interval Between Onset and Death<br>1 year  |   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  |   | Due to (or as a consequence of): |   |   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  | b.  | cigarette smoking                |   |   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  |   | Due to (or as a consequence of): |   |   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  | c.  |                                  |   |   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  | d.  |                                  |   |   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  |   |                                  |   |   |  |  |   | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  |   |                                  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   |                                  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  |   |                                  |   | 28d. Describe how injury occurred   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                                  |   | 29b. Signature and title of certifier<br>William Kelly  |  |  |   | 29c. License number<br>D39979  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
|  |   |                                  |   | 29d. Date signed (Month, Day, Year)<br>3/31/99  |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>William Kelly, M.D. 25500 Point Lookout Road, Leonardtown, Maryland 20650  |   |                                  |   |   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 1 1999  |   |                                  |   | 32. Registrar's Signature<br>Benjamin B. Sparks   |  |  |   |  |   |   |    |             |  |  |                                  |    |                   |  |                                  |  |    |  |  |  |    |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLARENCE HOWARD GREENFIELD

2. Date of Death

Month Day Year

March 20 1999

3. Time of Death

12:41 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health of Bel Air

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

215-16-6900

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 10, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2405 Whitt Road

10f. Zip Code

21087

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Parts &amp; Service Manager

16b. Kind of Business/Industry

County Government

17. Father's Name (First, Middle, Last)

Howard Herold Greenfield

18. Mother's Name (First, Middle, Maiden Surname)

Mary Viola Riley

19a. Informant's Name/Relationship (Type, Print)

Evelyn M. Greenfield - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2405 Whitt Road, Kingsville, MD 21087

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corp.

Date

3/22/99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

1317 Cokesbury Rd., Abingdon, MD 21009

23a. Enter the disease or condition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiorespiratory Arrest

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Acute and Chronic Aspiration due

Due to (or as a consequence of):

c. to Dysphagia from Neurogenic

Due to (or as a consequence of):

d. Cause

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Old Brain Injury (subdural Hematoma)

from Motor Vehicle Accident 1970

Cachexia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

29c. License number

29d. Date signed (Month, Day, Year)

D19583

March 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANUEL M. LAZARIN MD

8 Law Street  
21001 Aberdeen, Maryland

31. Date filed (Month, Day, Year)

MAR 22 1999

32. Registrar's Signature

B. G. [Signature]

1241

State

Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Greenfield Clarence

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.

*[Signature]*

Handwritten text, mostly illegible.

Handwritten text, mostly illegible.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12068

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>LINDA GIBSON</b>   |  |   |  | 2. Date of Death<br>Month <b>03</b> Day <b>24</b> Year <b>99</b>  |  | 3. Time of Death<br><b>0830</b>   |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>8197 Weyburn Road</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Millersville</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| 5. Social Security Number<br><b>213 54 6253</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>36</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>06/20/62</b>                                      |  |
| 9. Birthplace (State or Foreign Country)<br><b>Washington DC</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Millersville</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>8197 Weyburn Road</b>  |  | 10f. Zip Code<br><b>21108</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>None</b>                          |  | 16b. Kind of Business/Industry<br><b>Not Applicable</b>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Gibson</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marion Foard</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph Gibson (father)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4410 Sellman Rd/Beltsville MD 20705</b>   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>3/26/99</b>  |  | 20c. Location - City or Town, State<br><b>Alexandria VA</b>                                 |  |
| 21. Signature of Funeral Service Licensee<br><b>Melanie Wilhelm Waspe</b>   |  |   |  | 22. Name and Address of Facility<br><b>Advent Funeral &amp; Cremation Services<br/>Annapolis MD 21401</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Seizure</b><br>Due to (or as a consequence of):<br><br>b. <b>Epilepsy</b><br>Due to (or as a consequence of):<br><br>c. <b>mental retardation</b><br>Due to (or as a consequence of):<br><br>d. <b>Cornelia De Lange Syndrome</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>David C. Anderson MD</b>  |  |   |  | 29c. License number<br><b>D43236</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/24/99</b>                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID ANDERSON, MD<br/>2448 Holly Ave. Ste 100 Annapolis MD 21401</b>  |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  |   |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99-12069

## Certificate of Death

Reg. No.

|   |  |  |  |   |   |   |  |
|---|--|--|--|---|---|---|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>STANLEY EDWARD GILBERT</b>                                  |  |  |   | 2. Date of Death<br>Month <b>3</b> Day <b>26</b> Year <b>99</b> |   | 3. Time of Death<br><b>1828</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>        |   | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-01-9525</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                  | 8. Date of Birth (Month, Day, Year)<br><b>12-14-1916</b>                |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, D.C.</b>  |  |  |   |   |   |  |
| Usual Residence of Decedent   |  |  |  |   |   |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>WICOMICO</b>   |  | 10c. City, Town or Location<br><b>SALISBURY</b>   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br><b>218 POTOMAC AVE.</b>   |  |  |  | 10f. Zip Code<br><b>21804</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII NAVY</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |  |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALESMAN</b>  |   | 16b. Kind of Business/Industry<br><b>FOOD INDUSTRY</b>                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>STANLEY J. GILBERT</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JEANNETTE ALBRECHT</b>  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JEANNE L. GILBERT - WIFE</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>218 POTOMAC AVE. SALISBURY, MD 21804</b>  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CAMBRIDGE CREMATORY</b>  |   | Date<br><b>3/27/99</b>  | 20c. Location - City or Town, State<br><b>CAMBRIDGE, MD</b>                                    |
| 21. Signature of Funeral Service Licensee<br><b>B. Keith P. Lippert, CFSP</b>   |  |  |  | 22. Name and Address of Facility<br><b>705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804</b>  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>1 WEEK</b>  |  |  |  |   |   |   |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL FAILURE</b><br><b>HYPOCALCEMIA</b>  |  |  |  |   |   |   |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |   |   |   |  |
| 24a. Were an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 28d. Describe how injury occurred   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |   |   |   |  |
| 29b. Signature and title of certifier<br><b>B. Keith P. Lippert</b>   |  |  |  | 29c. License number<br><b>D36576</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/26/99</b>                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RONALD P. TRAVITZ and 560 RIVERSIDE DR, SALIS MD</b>   |  |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  |  |  | 32. Registrar's Signature<br><b>Sparks</b>  |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12070

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LUTHER BOOKER HAMILTON</b>                                  |  |  | 2. Date of Death<br>Month Day Year<br><b>03- 28 1999</b>  |  | 3. Time of Death<br><b>09:45</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital Center</b> |  |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>  |  | 4c. County of Death<br><b>Prince Georges</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-16-6031</b>  |  | 6. Sex<br><b>XX</b> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 27, 1915</b> |
|  | 9. Birthplace (State or Foreign Country)<br><b>Va.</b>   |  | 10a. State<br><b>Md.</b>                         |   | 10b. County<br><b>Prince Georges</b>             |  | 10c. City, Town or Location<br><b>Clinton</b>                |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>9211 Stuart Lane</b>   |  | 10f. Zip Code<br><b>20735</b>  |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>   |  | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jeremiah Hamilton</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Virginia Jones</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Larry Lee Hamilton /son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18817 Kerill Road, Triangle, Va. 22172</b>   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Quantico National Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Triangle, Va.</b>   |  | 20d. Date<br><b>4-1-99</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Bernard O Amor</b>   |  | 22. Name and Address of Facility<br><b>Ames Funeral Home, 8914 Quarry Rd. Manassas, Va. 20110</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b><br>Due to (or as a consequence of):<br><b>Sacral decubitus</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>1WK</b>   |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal insufficiency,</b><br><b>Old CVA, Dementia</b>   |  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  |
| 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>D46478</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3.29.99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Suresh A. Patel, M.D. 7501 Surrat Rd #307, Clinton, MD 20735</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12071

JAMES  
HARLANDPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James W. Harland

2. Date of Death

Month  
MARCH

Day

28, 1999

3. Time of Death

6:10P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

485-20-3469

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 8, 1925

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7929 Robison Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Structural Engineer

16b. Kind of Business/Industry

Civil Engineering

17. Father's Name (First, Middle, Last)

Joseph Leonard Harland

18. Mother's Name (First, Middle, Maiden Surname)

Blanche A. Allard

19a. Informant's Name/Relationship (Type, Print)

Barbara F. Harland (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

3-30-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?  
INSPECTION1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DAVID R. FOWLER M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID R. FOWLER M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12072**  
**Certificate of Death**

Reg. No.

|  |   |  |  |  |   |  |  |   |  |
|--|---|--|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ERWIN C. HANNUM</b>                                |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>30</b> , Year <b>1999</b> |  | 3. Time of Death<br><b>7:25 PM</b>                         |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>COLLINGTON HEALTH CENTER</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>MITCHELLVILLE</b>            |  | 4c. County of Death<br><b>PRINCE GEORGES</b>               |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-44-7295</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.                        |  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 4, 1908</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b>                                       |  | 10e. State<br><b>MD.</b>   |  | 10b. County<br><b>PRINCE GEORGES</b>                                    |  | 10c. City, Town or Location<br><b>MITCHELLVILLE</b>        |   |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>10450 LOTTSFORD RD.</b>   |   | 10f. Zip Code<br><b>20721</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PUBLIC ADMINISTRATOR</b>           |  | 16b. Kind of Business/Industry<br><b>FED. GOV'T.</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>RALPH HANNUM</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CORAL SNYDER</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JULIA ROSE/DAUGHTER</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2634 EAST 130th ST., CLEVELAND, OHIO 44120</b> |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHAMBERS CREMATORY</b>  |  | 20c. Location - City or Town, State<br><b>3/31/99 RIVERDALE, MD.</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   | 22. Name and Address of Facility<br><b>MOO091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Cardio pulmonary arrest</b><br>Due to (or as a consequence of):<br><b>Heart failure</b><br>Due to (or as a consequence of):<br><b>Anemia</b><br>Due to (or as a consequence of):<br><b>Macrocytosis / polycythemia</b> |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | Approximate Interval Between Onset and Death  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>D42033</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/31/99</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Martin Portillo MD, 1221 MERCANTILE LA, LARGO, MD. 20774</b>   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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VIANCA

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State of Maryland / Department of Health and Mental Hygiene

ELIZABETH ITEMS: #23 PART I, 27 PER MEO G770 4-14-99 WR. **Certificate of Death**

Reg. No.

99-12073

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |
|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Vianca L. Herrera</b>   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>15</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>14:57 PM</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGE'S HOSPITAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>PRINCE GEORGES</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>  |
| 5. Social Security Number<br><b>None</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>Yrs.</b>   | If Under 1 Year<br>Months <b>1</b> Days <b>2</b> | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 13, 1999</b>   |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10. Usual Residence of Decedent   |  |   |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Prince Georges</b>                                       | 10c. City, Town or Location<br><b>Landover</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
| 10e. Street and Number<br><b>7322 Landover Rd. # D</b>   |  | 10f. Zip Code<br><b>20785</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Dominican</b> |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+) <b>0</b>   |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>None</b>   |  | 16b. Kind of Business/Industry<br><b>None</b>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Jose L. Campusano</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minerva Herrera</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Minerva Herrera (Mother)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7322 Landover Rd. # D Landover, MD 20785</b>  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate Of Heaven Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>3/24/99 Silver Spring, MD</b>   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Rendon/Hale Funeral Home</b><br><b>9013 Annapolis Rd. Lanham, MD 20706</b>   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>PNEUMONIA</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown              |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>OCME</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 17, 1999</b>  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>THEODOR M. KING 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 13 1999</b>  |  | 32. Registrar's Signature<br>   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12074

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary H. Harvey

2. Date of Death  
Month Day Year  
March 31, 1999

3. Time of Death  
9:15 PM

4a. Facility Name (If not institution, give street and number)

CareMatrix of Silver Spring

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

215-74-1525

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov 2 1910

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10022 Lorain Avenue

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)  
12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John E. Byfield

18. Mother's Name (First, Middle, Maiden Summa)

Rose E. Unknown

19a. Informant's Name/Relationship (Type, Print)

Charles R. Harvey / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4712 Arbutus Avenue, Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

National Memorial Park 4-3-99 Falls Church, VA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Storn D Storn*

22. Name and Address of Facility Collins Funeral Home

500 University Blvd West, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Cardiovascular accident*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*48 hrs*

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Arteriosclerotic Cardiovascular Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

*Myron L. Lenkin MD*

29c. License number

*MD 006674*

29d. Date signed (Month, Day, Year)

*4/1/99*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*MYRON L. LENKIN MD*

*2309 SHOREFIELD RD WHITEHARTON MD*

31. Date filed (Month, Day, Year)

*APR 02 1999*

32. Registrar's Signature

*Beverly G. Sparks*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12075

|   |   |   |  |   |   |  |  |  |
|---|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>YOSHIO NAKAHARA HATFIELD                            |   |  |   | 2. Date of Death<br>Month Day Year<br>MARCH 29 1999   |  | 3. Time of Death<br>1746                             |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>3205 Weeping Willow Court #23 |   |  |   | 4b. City, Town, or Location of Death<br>SILVER SPRING   |  | 4c. County of Death<br>MONTGOMERY                    |  |
| Funeral<br>Director   | 5. Social Security Number<br>216-64-6788  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>66 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 11, 1932 |  |
|   | Usual Residence of Decedent   |   | 9. Birthplace (State or Foreign Country)<br>Japan                              |   | 10. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
| 10a. State<br>Maryland  |   | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Silver Spring  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>3205 Weeping Willow Court, #23  |   |   |  | 10f. Zip Code<br>20906  |   | 10g. Citizen of What Country?<br>United States   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Japanese                                |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>unavailable   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales Manager  |   | 16b. Kind of Business/Industry<br>Department Store   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Misaburo Nakahara  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Masa (Unavailable)   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Masako K. Leahy (friend)  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3133 Queens Chapel Road, #202, Mt. Rainier, MD 20712   |   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  | Date<br>3-30-99   |   | 20c. Location - City or Town, State<br>Beltsville, Maryland  |  |  |
| 21. Signature of Funeral Service Licensee<br>Carol A. Dehn  |   |   |  | 22. Name and Address of Facility<br>Rapp Funeral Services, P.A.<br>933 Gist Avenue, Silver Spring, MD 20910   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ANTERIOR SCROTIC CARDIOVASCULAR DISEASE<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HYPERTENSION  |   |   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  | 29b. Signature and title of certifier<br>M.D. (Mort)  |   | 29c. License number<br>015236  |  | 29d. Date signed (Month, Day, Year)<br>MARCH 29, 1999  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>CARL MAGAN, MD 1125 ROCKVILLE PIKE ROCKVILLE, MD 20852  |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 31 1999  |   | 32. Registrar's Signature<br>B. Sparks  |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12076

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>SHIRLEY HELLER                                    |   |   |  | 2. Date of Death<br>Month Day Year<br>MARCH 27, 1999 |  | 3. Time of Death<br>12:25 AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>MONTGOMERY GENERAL HOSPITAL |   |   |  | 4b. City, Town, or Location of Death<br>OLNEY        |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director  | 5. Social Security Number<br>116-24-5998  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>89 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Birth (Month, Day, Year)<br>NOV. 24, 1909   |  | 9. Birthplace (State or Foreign Country)<br>NEW YORK       |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |  |
| 10a. State<br>MARYLAND   |   | 10b. County<br>MONTGOMERY   |   | 10c. City, Town or Location<br>SILVER SPRING   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>14510 HOMECREST ROAD   |   |   |   | 10f. Zip Code<br>20906   |  | 10g. Citizen of What Country?<br>UNITED STATES   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER   |  |  | 16b. Kind of Business/Industry<br>OWN HOME   |  |
| 17. Father's Name (First, Middle, Last)<br>(UNKNOWN) HERMAN  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>UNAVAILABLE   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>ROBERT HELLER (SON)  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13613 RUSSETT TERRACE - ROCKVILLE, MARYLAND 20853   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>KING SOLOMON MEMORIAL PK.   |   | Date<br>3/30/99  |  | 20c. Location - City or Town, State<br>CLIFTON, NEW JERSEY   |  |  |
| 21. Signature of Funeral Service Licensee<br>Donald C. Stettin   |   |   |   | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. MYOCARDIAL INFARCTION<br>Due to (or as a consequence of):<br>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |  |  | Approximate Interval Between Onset and Death               |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HIP FRACTURE   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br>MARCH 26 1999   |   | 28b. Time of Injury<br>1000 M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>FELL ON FLOOR IN HALL |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>HOME  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br>M.D. (OM5)   |   | 29c. License number<br>015236  |  | 29d. Date signed (Month, Day, Year)<br>MARCH 29, 1999  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>CHALL MARGOLIS, MD (OM5) 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 30 1999   |   | 32. Registrar's Signature<br>B. Sparks  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99-12077

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |   |  |  |
|--|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Gene Lewis Hill, Sr.</b>                     |   |  |  | 2. Date of Death<br>Month Day Year<br><b>March 27, 1999</b> |   | 3. Time of Death<br><b>6:50 AM</b>                           |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1 Walnutwood Court</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Germantown</b>   |   | 4c. County of Death<br><b>Montgomery</b>                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>262-34-6195</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br><b>April 10, 1928</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Florida</b>                                  |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>                            |   | 10c. City, Town or Location<br><b>Germantown</b>             |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>1 Walnutwood Court</b>   |  | 10f. Zip Code<br><b>20874</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>World War II</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Printer</b>   |  | 16b. Kind of Business/Industry<br><b>United States Government</b>  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Claude Franklin Hill</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cleo P. Laws</b>   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Lou Green / daughter</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>283 Chelmsford Court, Sterling, Virginia 20165</b>                                       |   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>   |   |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Robert A. Pumphrey</i>   |   | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Rockville, Inc.</b>  |  | 300 West Montgomery Avenue, Rockville, Maryland 20850-2805   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br><i>Steven T. Coulter</i>   |  | 29c. License number<br><b>D39934</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 28, 1999</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Steven T. Coulter, M.D. 15201 Shady Grove Road, Suite 202, Rockville, MD 20850</b>  |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>  |   | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner







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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12078

|  |   |  |  |   |  |  |  |   |
|--|---|--|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>HILDA HOLLANDER   |  |  |   | 2. Date of Death<br>Month Day Year<br>MARCH 31, 1999 |  | 3. Time of Death<br>11:25 P.M.   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>HEBREW HOME OF GREATER WASHINGTON |  |  |   | 4b. City, Town, or Location of Death<br>ROCKVILLE    |  | 4c. County of Death<br>MONTGOMERY  |   |
| Funeral<br>Director  | 5. Social Security Number<br>213-58-8289  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F<br>XX | 7. Age (In yrs. last birthday)<br>85 Yrs.   | If Under 1 Year<br>Months Days                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>August 22, 1913   | 9. Birthplace (State or Foreign Country)<br>POLAND  |
|  | Usual Residence of Decedent   |  |  |   | 10c. City, Town or Location<br>SILVER SPRING         |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>XX |   |
| 10e. State<br>MARYLAND   |   | 10b. County<br>MONTGOMERY  |  | 10f. Zip Code<br>20904  |  | 10g. Citizen of What Country?<br>U. S. A.  |  |   |
| 10a. Street and Number<br>12809 TOURMALINE COURT   |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced<br>XX |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th GRADE<br>College (1-4or 5+) _____   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER  |  | 16b. Kind of Business/Industry<br>OWN HOME   |  |   |
| 17. Father's Name (First, Middle, Last)<br>AVRUM BARBASH   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>CHUMA (UNKNOWN)  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>BERNARD A. HOLLANDER - SON   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12809 TOURMALINE COURT, SILVER SPRING, MARYLAND 20904  |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MOUNT LEBANON CEMETERY  |  | 20c. Location - City or Town, State<br>ADELPHI, MARYLAND   |  | Date<br>4/4/1999  |
| 21. Signature of Funeral Service Licensee<br>Donald C. Statton   |   |  |  | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  | e. ASPIRATION PNEUMONIA<br>Due to (or as a consequence of):<br>b. DEMENTIA, VASCULAR<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____  |  |  |  | Approximate Interval Between Onset and Death<br>2 DAYS  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|  |   |  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |
|  |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|  |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |   |
|  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |  | 29c. License number<br>D18084   |  |  |  |   |
| 29b. Signature and title of certifier<br>D.D. Patel M.D.   |   |  |  | 29d. Date signed (Month, Day, Year)<br>APRIL 01, 1999   |  |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852   |   |  |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>APR 02 1999   |   |  |  | 32. Registrar's Signature<br>B. Sparks  |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12079**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

|   |  |  |  |   |                                |   |  |
|---|--|--|--|---|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Harry T. Holter</b>                                      |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>30</b> Year <b>1999</b> |                                | 3. Time of Death<br><b>2250</b>                             |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>              |                                | 4c. County of Death<br><b>Montgomery</b>                    |  |
| 5. Social Security Number<br><b>274-28-5619</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>April 4, 1933</b> |  |
| 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>   |  |  |  |   |                                |   |  |

Funeral  
Director

|  |  |                                  |  |
|--|--|----------------------------------|--|
| Usual Residence of Decedent  |  |                                  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b> |  |
| 10c. City, Town or Location<br><b>Darnestown</b>   |  |                                  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                  |  |

|  |  |                               |  |   |  |
|--|--|-------------------------------|--|---|--|
| 10e. Street and Number<br><b>14423 Seneca Road</b> |  | 10f. Zip Code<br><b>20874</b> |  | 10g. Citizen of What Country?<br><b>United States</b> |  |
|--|--|-------------------------------|--|---|--|


|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean Conflict</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|--|--|--|--|--|--|---|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Safety Engineer</b> |  | 16b. Kind of Business/Industry<br><b>US Navy</b> |  |
|---|--|---|--|--|--|

|  |  |  |  |
|--|--|--|--|
| 17. Father's Name (First, Middle, Last)<br><b>Sumner R. Holter</b> |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Roush</b> |  |
|--|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Deborah W. Holter/Wife</b> |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14423 Seneca Road, Darnestown, Maryland 20874</b> |  |
|---|--|---|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b> |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b> |  |
|---|--|---|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 21. Signature of Funeral Service Licensee<br> <b>MO1126</b> |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b> |  |
|---|--|---|--|

|   |  |   |  |
|---|--|---|--|
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Non Small Cell Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>7 1/2 Months</b> |  | Approximate Interval Between Onset and Death<br><b>7 1/2 Months</b> |  |
|---|--|---|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pulmonary Disease</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|--|--|--|--|


|   |  |   |  |
|---|--|---|--|
| <b>Hypertensive and Arteriosclerotic Cardiovascular</b> |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|---|--|---|--|

|   |  |  |  |
|---|--|--|--|
| <b>Disease with Stroke, Non Insulin Dependent Diabetes Mellitus</b> |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|---|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
|---|--|---|--|

|   |  |  |  |  |  |   |  |                                   |  |
|---|--|--|--|--|--|---|--|-----------------------------------|--|
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |                                   |  |

|   |  |                                       |  |  |  |
|---|--|---------------------------------------|--|--|--|
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29c. License number<br><b>D 07285</b> |  | 29d. Date signed (Month, Day, Year)<br><b>March 31, 1999</b> |  |
|---|--|---------------------------------------|--|--|--|

|  |  |                                       |  |  |  |
|--|--|---------------------------------------|--|--|--|
| 29b. Signature and title of certifier<br> <b>James A. Brown, M.D.</b> |  | 29c. License number<br><b>D 07285</b> |  | 29d. Date signed (Month, Day, Year)<br><b>March 31, 1999</b> |  |
|--|--|---------------------------------------|--|--|--|

|   |  |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James A. Brown, M.D. 9707 Medical Center Drive Rockville, Maryland 20850</b> |  |
|---|--|

|   |  |   |  |
|---|--|---|--|
| 31. Date filed (Month, Day, Year)<br><b>APR 02 1999</b> |  | 32. Registrar's Signature<br> |  |
|---|--|---|--|

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12080

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Thomas Howard

2. Date of Death

March 22 1999

3. Time of Death

1315

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville MD

4c. County of Death

Montgomery

5. Social Security Number

578-58-7770

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 4, 1904

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19323 Dunbridge Way

10f. Zip Code

20886

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chemist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Vincent A. Howard

18. Mother's Name (First, Middle, Maiden Surname)

Mary Dasenbrock

19a. Informant's Name/Relationship (Type, Print)

Kathleen H. Bradley (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19323 Dunbridge Way Montgomery Village, Maryland 20886

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

3/27/99 Silver Spring, Maryland

21. Signature of Funeral Service Licensee

William L. B. J.

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Approximate Interval Between Onset and Death

minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Angelo Falcone, M.D.

29c. License number

044380

29d. Date signed (Month, Day, Year)

March 22, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Angelo Falcone, M.D. 9901 Medical Center Drive Rockville, MD. 20850

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

30



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Zella Franklin Hargraves

2. Date of Death

Month Day Year  
March 28, 1999

3. Time of Death

8:00 p.m.

4a. Facility Name (If not institution, give street and number)

6160 Rock Hall Road (Residence)

4b. City, Town, or Location of Death

Rock Hall

4c. County of Death

Kent

5. Social Security Number

577-01-5746

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
April 23, 1916

9. Birthplace (State or Foreign Country)

Stouts Mills, W

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Rock Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6160 Rock Hall Road

10f. Zip Code

21661

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

Collage (1-4or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Restuarant Manager

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

Rosen Franklin

18. Mother's Name (First, Middle, Maiden Surname)

Audra Brown

19a. Informant's Name/Relationship (Type, Print)

Pam Stenger/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6160 Rock Hall Road, Rock Hall, Maryland 21661

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Center, LLC

Date

3/29/99

20c. Location - City or Town, State

Stevensville, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.  
130 Spear Road, Chestertown, Maryland 21620

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cardio Respiratory Arrest

Due to (or as a consequence of):

ASCVD<sub>2</sub>

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

3 hours

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

HTN, Pacemaker, Carotid Stenosis 100%<sup>R</sup> Side  
60%<sup>OS</sup> Side, TIA, CVA, Elevated Cholesterol

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D 50996

29d. Date signed (Month, Day, Year)

3/29/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Neil Stoddard 100 Brown St. Chestertown MD 21620

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12082

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH LENORA MURDOCK HALLBERG

2. Date of Death

MARCH 30, 1999

3. Time of Death

5:15AM

4a. Facility Name (If not institution, give street and number)

11 FIRST STREET

4b. City, Town, or Location of Death

INDIAN HEAD

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

096-12-3206

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 7, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Indian Head

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11 First Street

10f. Zip Code

20640

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
Unknown

College (1-4or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

18b. Kind of Business/Industry

Her Home

17. Father's Name (First, Middle, Last)

Elliot Maus

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Warnock

19a. Informant's Name/Relationship (Type, Print)

Clifford W. Murdock, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Funeral Services

Date

March 31, 1999

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Williams Funeral Home, P.A.

M00668

4270 Hawthorne Rd., Indian Head, Md. 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease  
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

XX Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Attending Physician

29c. License number

D-46419

29d. Date signed (Month, Day, Year)

March 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

404 E. Charles St La Plata MD 20646

Charlene A. Letchford, M.D.

State  
Registrar

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12083

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Mae Harrison

2. Date of Death

March 19 1999

3. Time of Death

0230

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

219-50-9753

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

8. Date of Birth (Month, Day, Year)

Feb. 24, 1907

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

108 Idlewild Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)  
1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retail Merchant

16b. Kind of Business/Industry

Retail Store

17. Father's Name (First, Middle, Last)

Edward (U/K) Tarring

18. Mother's Name (First, Middle, Maiden Surname)

Laura Belle Bowen

19a. Informant's Name/Relationship (Type, Print)

George F. Harrison/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Duncannon Road, Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens 3-21-99 Bel Air, Maryland

21. Signature of Funeral Service Licensee

Charles A. Emery, Jr.

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
50 W. Broadway Street, Bel Air, Maryland 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Kevin Lynch MD

29c. License number

D35012

29d. Date signed (Month, Day, Year)

MARCH 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Kevin Lynch, MD 2 North Ave. Bel Air, MD 21014

31. Date filed (Month, Day, Year)

MAR 22 1999

Registrar's Signature

B. B. Spauld

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12084

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |  |  |  |                                |  |  |
|---|--|--|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>William Reed Hammond</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>March 18, 1999</b>  |                                | 3. Time of Death<br><b>11:45 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>733 Falconer Road</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Joppa</b>   |                                | 4c. County of Death<br><b>Harford</b>  |  |
| 5. Social Security Number<br><b>311-10-3077</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 19, 1914</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Indiana</b>  |  |  |  |  |                                |  |  |
| Usual Residence of Decedent   |  |  |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Joppa</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>733 Falconer Road</b>  |  |  |  | 10f. Zip Code<br><b>21085</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineering Draftsman</b>  |                                | 16b. Kind of Business/Industry<br><b>U.S. Government</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frederick Cecil Hammond</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pearl Amelia Mossman</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>June H. Hammond/ Wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>733 Falconer Road, Joppa, MD 21085</b>   |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Trinity Lutheran Chr. Cem.</b>  |  | 20c. Location - City or Town, State<br><b>Joppa, Maryland</b>  |                                | 20d. Date<br><b>3-22-99</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Holly K. McComas</i>  |  |  |  | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>End stage chronic obstructive pulmonary disease</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Benign Prostatic Hypertrophy</b> |  |  |  |  |                                | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Benign Prostatic Hypertrophy</b>   |  |  |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |                                |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><i>Robert S. Knight, MD</i>  |  |  |  | 29c. License number<br><b>D38933</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>03/19/99</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert S. Knight, MD</b>   |  |  |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 22 1999</b>   |  |  |  | 32. Registrar's Signature<br><i>Brian A. Smith</i>   |                                |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12085

|  |  |  |   |  |  |  |  |  |   |  |
|--|--|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Harold Jack Hale</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 26, 1999</b>  |  |  |  | 3. Time of Death<br><b>12:30 AM</b>                               |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3555 Mill Green Road</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Street</b>  |  |  |  | 4c. County of Death<br><b>Harford</b>                             |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-28-5555</b>  |  | 6. Sex<br><b>XX</b> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>67</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>10/10/31</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Comers Rock VA</b> |  |
|  | 10a. State<br><b>MD</b>  |  |   |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Street</b>   |  |   |  |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br><b>3555 Mill Green Rd.</b>   |  |   |  | 10f. Zip Code<br><b>21154</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1950-52</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>   |  | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Floyd Hale</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie Hackler</b>   |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jane Hale- wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3555 Mill Green Rd., Street, MD 21154</b>  |  |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Tabor Cemetery, 3/30/99</b>  |  | 20c. Location - City or Town, State<br><b>Forest Hill, MD</b>  |  |  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Harkins F.H. Inc., PO Box 485, Delta, PA 17314</b>  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ASCVD</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  |   |  | Approximate Interval Between Onset and Death   |  |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  |  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|  |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                                 |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br> <b>DME</b>   |  | 29c. License number<br><b>OCME</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1999</b>   |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ganesh Prabhu, M.D. 218 Fulford Ave. Bel Air, MD 21014</b>  |  |   |  |  |  |  |  |   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>  |  | 32. Registrar's Signature<br>   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page]*



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12086

|   |  |                             |  |  |  |  |   |  |   |  |  |                             |  |   |  |
|---|--|-----------------------------|--|--|--|--|---|--|---|--|--|-----------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>James Milton Hasselhoff, Jr.             |                             |  |  |  | 2. Date of Death<br>Month Day Year<br>MARCH 28, 1999 |   | 3. Time of Death<br>1650 PM  |   |  |  |                             |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>24 EAST BAY BRIDGE |                             |  |  |  | 4b. City, Town, or Location of Death<br>ANNAPOLIS    |   | 4c. County of Death<br>ANNE ARUNDEL  |   |  |  |                             |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-90-4510   |                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>34 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Mar 22, 1965   |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  |  |                             |  |   |  |
|   | Usual Residence of Decedent  |                             |  |  |  |  |   |  |   |  |  |                             |  |   |  |
| 10e. State<br>MD  |  | 10b. County<br>Anne Arundel |  | 10c. City, Town or Location<br>Annapolis |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |                             |  |   |  |
| 10e. Street and Number<br>570 Bellerive Drive   |  |                             |  |  | 10f. Zip Code<br>21401   |  | 10g. Citizen of What Country?<br>USA  |  |   |  |  |                             |  |   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1984   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   |  |  |                             |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3   |  |                             |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |  |   | 16b. Kind of Business/Industry   |   |  |  |                             |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>James M. Hasselhoff, Sr.   |  |                             |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Phyllis A. Bender   |  |   |  |   |  |  |                             |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Phyllis A. Schwinger / mother   |  |                             |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>494 Century Vista Drive, Arnold, MD 21012   |  |   |  |   |  |  |                             |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory  |  | Date<br>Mar 31 1999  |  | 20c. Location - City or Town, State<br>Baltimore, MD  |  |   |  |  |                             |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>James E. Barranco</i>   |  |                             |  |  | 22. Name and Address of Facility<br>Barranco & Sons, P.A. Severna Park Funeral Home<br>495 Gov. Ritchie Hwy., Severna Park, MD 21146   |  |   |  |   |  |  |                             |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Multiple Injuries AND Drowning<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |                             |  |  |  |  |   |  |   | Approximate Interval Between Onset and Death                     |  |                             |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Schizophrenia   |  |                             |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |                             |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                             |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |                             |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                             | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE |  |  |  |   |  |   |  |  |                             |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |                             | 28a. Date of Injury (Month, Day, Year)<br>3-28-99  |  | 28b. Time of Injury<br>1638P M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br>Summer Jumped from Bridge<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Bridge AND BODY OF WATER CHESAPEAKE BAY BMDQ, ES. A. A CO, MD |  |  |                             |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>and manner stated.   |  |                             |  |  |  |  |   |  |   | 29b. Signature and title of certifier<br><i>Wynette D. Kover</i> |  | 29c. License number<br>OCME |  | 29d. Date signed (Month, Day, Year)<br>MARCH 29, 1999 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Wynette D. Kover 111 Penn Street, Baltimore, Maryland 21201   |  |                             |  |  |  |  |   |  |   |  |  |                             |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 30 1999  |  |                             | 32. Registrar's Signature<br><i>Wynette D. Kover</i>   |  |  |  |   |  |   |  |  |                             |  |   |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12087

DANIEL  
HANSEN

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |   |
|---|---|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>Daniel Joseph Hansen III</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 28, 1999</b>  |  | 3. Time of Death<br><b>8:28 P.M.</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death  |   |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>207-32-2921</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 17, 1943</b>  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                             |
|   | Usual Residence of Decedent   |  |   |   |  |  |   |
| To Be Completed by Funeral Director                     | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Annapolis</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
|   | 10e. Street and Number<br><b>3001 ValleyView Road</b>   |  |   | 10f. Zip Code<br><b>21401</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>        |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Compliance Officer</b>  |   | 16b. Kind of Business/Industry<br><b>State Government</b>  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Daniel J. Hansen II</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Neary</b>   |  |  |   |
| To Be Completed by Physician/Medical Examiner           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathleen M. Hansen / Wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3001 ValleyView Rd. Annapolis, MD 21401</b> |  |  |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |   | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |  | 20d. Date<br><b>3/29/99</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home Inc<br/>147 Duke of Gloucester St. Annapolis, MD 21401</b>                   |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |  |   |
| To Be Completed by Physician/Medical Examiner           | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |   |  |  |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |   |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |   |
| State Registrar   | 29b. Signature and title of certifier<br>   |  |   | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 28, 1999</b> |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARGARET A. KOROSUM 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b> |   | 32. Registrar's Signature<br>  |   |   |  |  |   |

Baltimore, Maryland 21215-0020

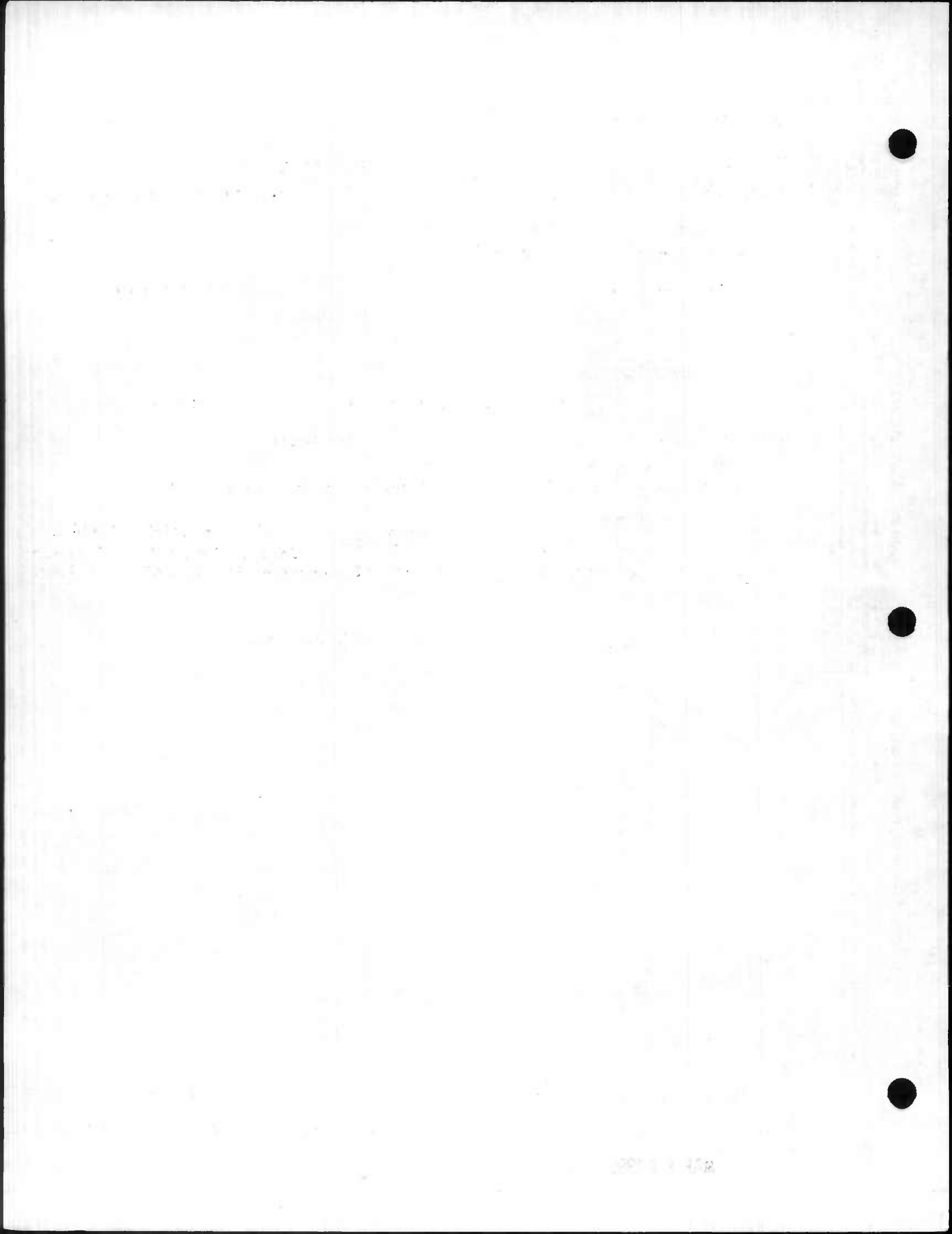
Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12088

|  |  |   |  |  |   |  |   |  |
|--|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ELYSE GARRISON (EILER) HARMON</b>           |   |  |  | 2. Date of Death<br>Month Day Year<br><b>March 19, 1999</b> |  | 3. Time of Death<br><b>10:30 pm</b>                         |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b>                      |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-32-7911</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>June 11, 1936</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>ALLEGANY</b>                              |  | 10c. City, Town or Location<br><b>CUMBERLAND</b>            |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1522-B OLDTOWN MANOR</b>   |  | 10f. Zip Code<br><b>21502</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>REGISTERED NURSE</b>  |  | 16b. Kind of Business/Industry<br><b>NURSING</b>   |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>FREDERIC WILLIAM EILER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY MARTHA WORKMEISTER</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY BERKELEY HARMON-ROBEY/DAU.</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>127 HANOVER STREET, CUMBERLAND, MD 21502</b>   |   |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CUMBERLAND CREMATORY</b>   |  | Date<br><b>3/21/99</b>   |   | 20c. Location - City or Town, State<br><b>CUMBERLAND, MD</b>                         |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Adenocarcinoma</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br><b>1 year</b>  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |
| 29a. Certifier (Check one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  | 29c. License number<br><b>012779</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/20/99</b>                                |   |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. G. Fiscus, Memorial Hospital Medical Bldg., Cumberland, MD 21502</b>                                      |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 24 1999</b>  |  | 32. Registrar's Signature<br>   |  |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12089

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUBY MERLE HAPNEY

2. Date of Death

Month Day Year  
MARCH 29, 1999

3. Time of Death

08:47 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

213-24-5665

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APRIL 9, 1915

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

WV

10b. County

MINERAL

10c. City, Town or Location

RIDGELEY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

ROUTE 1, BOX 524

10f. Zip Code

26753

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

SMAUEL ROBY WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

VERNA M. HEBB

19a. Informant's Name/Relationship (Type, Print)

NANCY PARSONS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 204 - PARSONS, WV 26287

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

PARSONS CEMETERY

Date

4/2/99

20c. Location - City or Town, State

PARSONS, WV

21. Signature of Funeral Service Licensee

*Standy A. Ypschance*

22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE ST., CUMBERLAND, MD 21502

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. GI BLEED - MASSIVE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Signature and title of certifier

*Terry Williams M.D.*

29d. License number

D16041

29e. Date signed (Month, Day, Year)

April 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terry Williams, M.D. - 500 Memorial Avenue, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

*[Signature]*State  
Registrar

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

HAPNEY, RUBY M. 213-24-5665







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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12090

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Esther Marie Evans Hackett

2. Date of Death

Month

Day

Year

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4a. Facility Name (If not institution, give street and number)

PENNSINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

222-05-0388

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 12, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Harrington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

206 West Street

10f. Zip Code

19952

10g. Citizen of What Country?

USA

11. Marital Status



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 12091

|  |   |   |  |   |   |  |   |   |   |  |  |
|--|---|---|--|---|---|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGIA HELEN KIRBY HEDGE</b>                |   |  |   | 2. Date of Death<br>Month Day Year<br><b>March 24, 1999</b> |  | 3. Time of Death<br><b>8:10 PM</b>                          |   |   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>109 Whayland Drive</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Hebron</b>       |  | 4c. County of Death<br><b>Wicomico</b>                      |   |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>231-24-2174</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>April 3, 1909</b> |   |   |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                 |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Wicomico</b>                              |  | 10c. City, Town or Location<br><b>Hebron</b>                |   |   |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>109 Whayland Drive</b>   |   | 10f. Zip Code<br><b>21830</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                       |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Domestic</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Daniel Bragg Kirby</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertha Maude Schrader</b> |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley Mulford/Daughter</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>109 Whayland Dr., Hebron, MD 21830</b>  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pentecostal Holiness Church Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Dublin, VA</b>                          |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>David H. Thompson</b> MO/OS/   |   | 22. Name and Address of Facility<br><b>Holloway Funeral Home Professional Association<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. carcinoma of lung</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   | Approximate Interval Between Onset and Death<br><b>6 months</b>  |   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |  |  |
|  |   |   |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>Charles B. Silvia Jr MD</b>           |   | 29c. License number<br><b>D30853</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>3/25/99</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charles B. Silvia Jr MD 100 Power Street Salisbury MD 21804</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 25 1999</b>   |   | 32. Registrar's Signature<br><b>Beverly S Sparks</b>   |   |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12092

|   |  |  |   |   |  |  |  |  |
|---|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BETTY STUBBS HATTON</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>March 25, 1999</b>  |  | 3. Time of Death<br><b>4:50 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>103 Howard St.</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Hebron</b>  |  | 4c. County of Death<br><b>Wicomico</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>227-48-8793</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>November 4, 1929</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Wicomico</b>   |  | 10c. City, Town or Location<br><b>Hebron</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>103 Howard St.</b>   |   | 10f. Zip Code<br><b>21830</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | College (1-4 or 5+) <b>-</b>  |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>Domestic</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Farmer Leroy Stubbs</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maude Jane Blevins</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Norman N. Hatton/Husband</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>103 Howard St., Hebron, MD 21830</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Springhill Memory Gardens</b>  |   | Date<br><b>3/27/99</b>   |  | 20c. Location - City or Town, State<br><b>Hebron, MD</b>   |  |
|   | 21. Signature of Funeral Director Licensee<br><i>David H. Thompson</i> MO1051  |  | 22. Name and Address of Facility<br><b>Holloway Funeral Home Professional Association<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>              |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Small Cell Undifferentiated Large Cell 3mo</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28e. Date of Injury (Month, Day, Year)                                       |   | 28b. Time of Injury<br><b>M</b>                       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Joseph A. Grasso</i>  |  |  |   | 29c. License number<br><b>020507</b>                  |  | 29d. Date signed (Month, Day, Year)<br><b>3/25/99</b>                            |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Joseph A. Grasso 145 E Carroll St Salisbury MD</b>   |  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  |  |   | 32. Registrar's Signature<br><i>Shirley S. Sparks</i> |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES H HART

2. Date of Death

Mar 14 1999 11:55 Am

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

136-01-8303

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jul 18, 1909

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

FL

10b. County

Lake

10c. City, Town or Location

Clearmont

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

540 Mar-Nan-Mar

10f. Zip Code

34711

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1939-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
Grade 12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Lieutenant

16b. Kind of Business/Industry

Newark, New Jersey  
Police Department

17. Father's Name (First, Middle, Last)

Henry John Hart

18. Mother's Name (First, Middle, Maiden Surname)

Carolyn Stuart

19a. Informant's Name/Relationship (Type, Print)

Robert Hart /son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39 Torrington Lane, Shoreham, New York 11786

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Hill Cemetery

Date

3/19/99

20c. Location - City or Town, State

Clearmont, Florida

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Donaldson Funeral Home, P.A.  
313 Talbott Ave. Laurel, Maryland 20707-4389

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

7 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D35217

29d. Date signed (Month, Day, Year)

Mar 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID JACKSON, MD

11055 Little Patuxent Pkwy Suite 209  
Columbia, MD 21044

31. Date filed (Month, Day, Year)

MAR 16 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12094

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

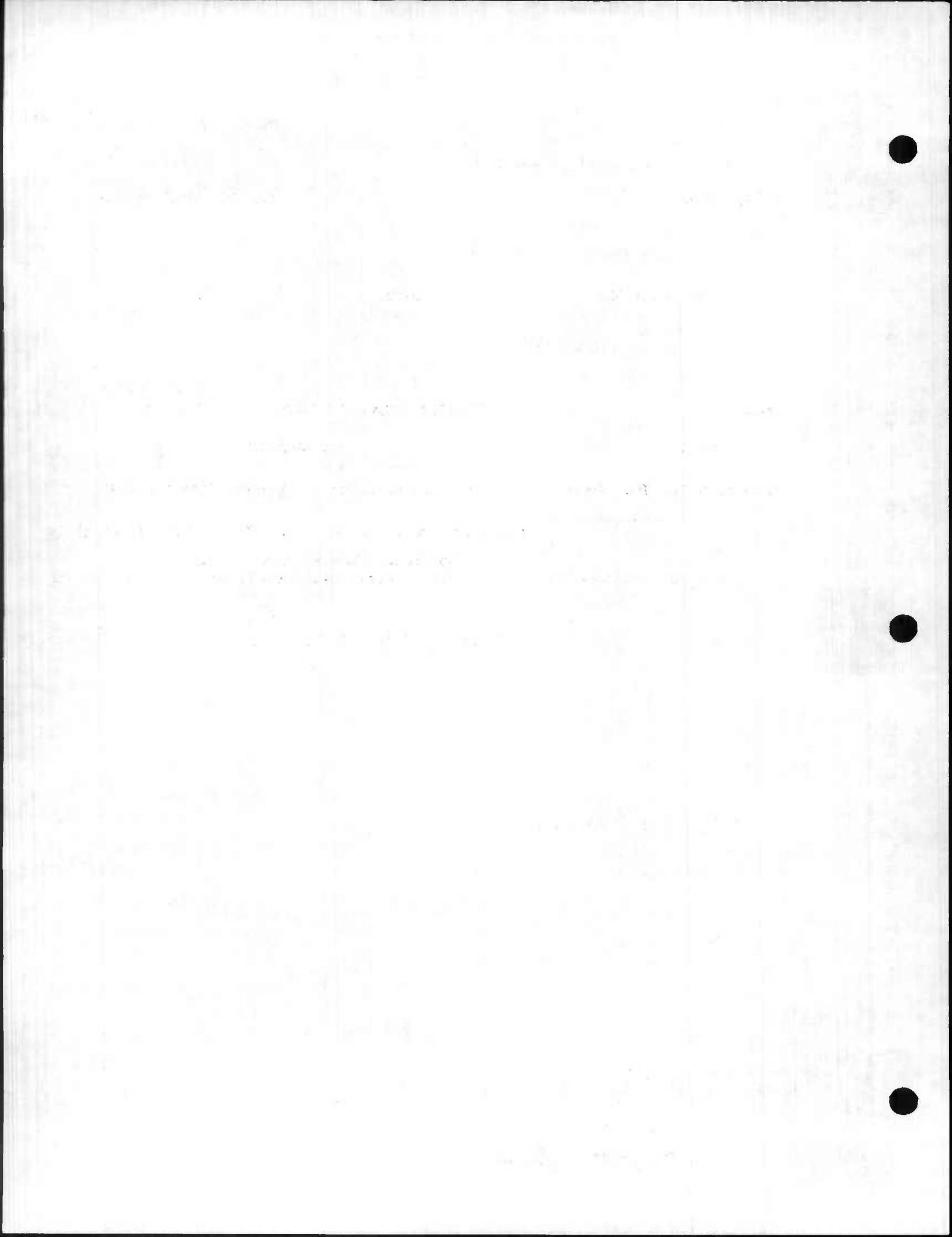
Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>John W. Holt</b>  |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>15</b> Year <b>1999</b>   |  |   |  | 3. Time of Death<br><b>11:15 AM</b>  |  |   |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Laurel Regional Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>   |  |   |  | 4c. County of Death<br><b>Prince George's</b>  |  |   |  |  |  |
| 5. Social Security Number<br><b>217-34-0802</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec 03, 1910</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b>   |  |
| Usual Residence of Decedent  |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George</b>  |  | 10c. City, Town or Location<br><b>Laurel</b>  |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |  |  |
| 10e. Street and Number<br><b>9258 Cherry Lane #27</b>  |  |  |  | 10f. Zip Code<br><b>20708</b>   |  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1929-53</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 7</b> College (1-4or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Property Disposal Officer</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>United States Government</b>                              |  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Tilmon Holt</b>  |  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Hughett</b>  |  |  |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John W. Holt, Jr. /son</b>  |  |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1424 Highwood Drive, McLean, Virginia 22101</b> |  |  |  |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cem</b>   |  | Date<br><b>3/23/99</b>  |  | 20c. Location - City or Town, State<br><b>Arlington, Virginia</b>                              |  |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |  |  |   |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707-4389</b>                            |  |  |  |   |  |  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. end-stage pulmonary fibrosis</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. cor pulmonale</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d. |  |  |  |   |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>6 years</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>cor pulmonale</b>   |  |  |  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how Injury occurred   |  |  |  |
|  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |   |  | 29c. License number<br><b>D0053801</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/16/99</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>8317 Cherry Lane Laurel MD 20707</b>  |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1999</b>  |  |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |  |  |   |  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DAVID

State of Maryland / Department of Health and Mental Hygiene

HERBERT ITEMS: #23PART I, 28A-F PER MEO G770 4-14-99 W

Certificate of Death

Reg. No.

99 12095

|   |   |   |  |  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
|---|---|---|--|--|---|---|--|--|---|----|----------------------|----------------------------------|--|----|--|----|--|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>David Lester Herbert                      |   |  |  | 2. Date of Death<br>Month Day Year<br>APRIL 1, 1999 |   | 3. Time of Death<br>10:34 P.M.   |  |   |    |                      |                                  |  |    |  |    |  |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>UNIVERSITY HOSPITAL |   |  |  | 4b. City, Town, or Location of Death<br>BALTIMORE   |   | 4c. County of Death<br>Baltimore   |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| Funeral<br>Director   | 5. Social Security Number<br>234-08-8914  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>37 Yrs.  | If Under 1 Year<br>Months Days                      | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>5/5/61  | 9. Birthplace (State or Foreign Country)<br>Charles Town, WV   |   |    |                      |                                  |  |    |  |    |  |    |  |
|   | Usual Residence of Decedent   |   |  |  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 10a. State<br>Md  |   | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Baltimore   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 10e. Street and Number<br>3000 St. Paul St. Apt #512  |   |   |  | 10f. Zip Code<br>21215   |   | 10g. Citizen of What Country?<br>US   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                               |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th College (14 or 5+) College (14 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Artist  |   |   | 16b. Kind of Business/Industry<br>Self Employed  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 17. Father's Name (First, Middle, Last)<br>Anthony T. Herbert, Sr.  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Thelma L. Newman  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Todd Herbert  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3 Meadow Court Charles Town, WV 25414   |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gibsonstown Cemetery   |   | 20c. Location - City or Town, State<br>Charles Town, WV   |  | 20d. Date<br>4/9/99  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 21. Signature of Funeral Service Licensee<br><i>Robert C. Field</i>   |   |   |  | 22. Name and Address of Facility<br>Jefferson Chapel Funeral Home<br>PO Box 838 Charles Town 25414   |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>COCAINE INTOXICATION</td> <td rowspan="4">           Due to (or as a consequence of):         </td> <td rowspan="4">           Approximate Interval Between Onset and Death         </td> </tr> <tr> <td>b.</td> <td></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |   |  |  |   |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | COCAINE INTOXICATION | Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. |  | c. |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.  | COCAINE INTOXICATION  | Due to (or as a consequence of):   | Approximate Interval Between Onset and Death   |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
|   | b.  |   |  |  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
|   | c.  |   |  |  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
|   | d.  |   |  |  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |    |                      |                                  |  |    |  |    |  |    |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br>Found: 4-1-99   |  | 28b. Time of Injury<br>Found: 10:23  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br>UNKNOWN   |   |    |                      |                                  |  |    |  |    |  |    |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Underneath END OF AUTO  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 400 BLOCK W. BALTIMORE ST. BALTIMORE, MARYLAND  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 29b. Signature and title of certifier<br><i>Mayra A. Kossou</i>   |   |   |  | 29c. License number<br>O.C.M.E.  |   | 29d. Date signed (Month, Day, Year)<br>APRIL 2, 1999  |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Mayra A. Kossou 111 Penn Street, Baltimore, Maryland 21201  |   |   |  |  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |
| State Registrar   |   | 31. Date filed (Month, Day, Year)<br>APR 12 1999  |  | 32. Registrar's Signature<br><i>B. Sparks</i>  |   |   |  |  |   |    |                      |                                  |  |    |  |    |  |    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 33a or 33b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12096

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ANNABELLE MCNAMARA HERD

2. Date of Death

Month Day Year  
MARCH 17, 1999

3. Time of Death

22:50

4a. Facility Name (If not institution, give street and number)

UNIV. OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-32-0896

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 22 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

Trappe

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

29441 Maple Ave.

10f. Zip Code

21673

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Thomas Leonard Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Lena McNamara

19a. Informant's Name/Relationship (Type, Print)

Vernon J. Herd - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29441 Maple Ave., Trappe MD 21672

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

East New Market Cemetery

Date

3-20-99

20c. Location - City or Town, State

East New Market Md.

21. Signature of Funeral Service Licensee

Kenneth R. Thomas

22. Name and Address of Facility

Thomas Funeral Home, P.A.  
700 Locust St., Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEAD INJURY WITH MASSIVE INTRACRANIAL HEMORRHAGE 5+HRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ANTICOAGULATION FOR OCCLUSIVE CAROTID VEIN DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

MARCH 17 1999 ± 2.0 P M

28b. Time of Injury

2:00 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FALL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29441 E. MAPLE AVE. TRAPPE, MD

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph M. Lyons, M.D., Attending Surgeon

29c. License number

D23286

29d. Date signed (Month, Day, Year)

MARCH 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST. UMMS.

22 South GREENEST. BALTO, MD 21201

31. Date filed (Month, Day, Year)

APR 08 1999

32. Registrar's Signature

Denise B. Sparks

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12097

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Martin Iwanski, Sr.

2. Date of Death

March 29 1999

3. Time of Death

2200

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

143-28-2812

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov. 7, 1936

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

607 Buoy Court

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1954  
1957

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Systems Designer

16b. Kind of Business/Industry

Aerospace

17. Father's Name (First, Middle, Last)

Jacob (NMN) Iwanski

18. Mother's Name (First, Middle, Maiden Surname)

Frances (NMN) Fornczek

19a. Informant's Name/Relationship (Type, Print)

Betty J. Iwanski/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

607 Buoy Court, Edgewood, MD 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenville Mem. Gardens

Date

4/3/99

20c. Location - City or Town, State

Greenville, SC

21. Signature of Funeral Service Licensee

Stephen A. Hughes

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

few hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

710 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Claudia A. Kroker MD

29c. License number

D50040

29d. Date signed (Month, Day, Year)

03-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLAUDIA A. KROKER, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amend #19a, 4/2/99, BMW, Montg. Co.

99 12098

|   |  |   |   |  |   |  |  |   |  |
|---|--|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT A. JACKSON</b>                           |   |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 27, 1999</b>   |  | 3. Time of Death<br><b>9:45 PM</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ManorCare of Bethesda</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-03-8831</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                          | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 8, 1908</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |
|   | Usual Residence of Decedent  |   |   |  |   |  |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Rockville</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>315 Lincoln Avenue</b>   |  |   |   | 10f. Zip Code<br><b>20850</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                               |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrician</b>  |   |  | 16b. Kind of Business/Industry<br><b>Naval Medical Center</b>                                  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Isaac Jackson</b>   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie ?</b>  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elsie Mae Jackson (Wife)</b><br><b>Elsie</b>   |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>315 Lincoln Ave., Rockville, MD 20850</b> |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Mem. Park</b> |  | Date<br><b>4/3/99</b>   |  | 20c. Location - City or Town, State<br><b>Rockville, MD</b>                                    |   |  |
| 21. Signature of Funeral Service Licensee<br><i>George R. Snowden</i>   |  |   |   |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>sepsis</b><br>Due to (or as a consequence of):<br><b>Pneumonia</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Diabetes, Renal failure</b> |  |   |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>few weeks</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes, Renal failure</b>  |  |   |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |  |
|   |  |   | 28d. Describe how injury occurred   |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |   |  |  | 29b. Signature and title of certifier<br><i>G. Chablan</i>  |  |
|   |  |   |   |  |   |  |  | 29c. License number<br><b>D42518</b>  |  |
|   |  |   |   |  |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1999</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gul Chablani, M.D. 11119 Rockville Pike, Rockville, MD 20852</b>   |  |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |  |   |   | 32. Registrar's Signature<br><i>Benita B. Sparks</i>   |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4 (2)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 12 Per FH FilmG770 4-26-99 rja

## Certificate of Death

Reg. No.

99 12099

|  |  |   |  |  |   |   |  |   |  |
|--|--|---|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph T. Jewell, Jr.</b>                             |   |  |  | 2. Date of Death<br>Month Day Year<br><b>March 30, 1999</b> |   | 3. Time of Death<br><b>1:58 AM</b>       |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Montgomery General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Olney</b>        |   | 4c. County of Death<br><b>Montgomery</b> |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-20-2225</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>June 7, 1925</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |  |
|  | Usual Residence of Decedent  |   |  |  |   |   |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Olney</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
| 10e. Street and Number<br><b>19100 Bloomfield Rd</b>   |  |   |  | 10f. Zip Code<br><b>20832</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1943-1946</b><br>If Yes, Give Year or Dates: <b>1946</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Public Health Analyst</b>  |   | 16b. Kind of Business/Industry<br><b>U.S. Public Health Service</b>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph T. Jewell</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jessie Murdock</b>   |   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara J. Jewell/Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3204 Spartan Rd, #11, Olney, MD 20832</b>  |   |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Crematory</b>   |  | Date<br><b>Apr 2</b>   |   | 20c. Location - City or Town, State<br><b>Brentwood, MD</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Alan J. Donnell</b>  |  |   |  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home<br/>11800 New Hampshire Ave, Silver Spring, MD 20904</b>   |   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ASCENDING CHOLANGITIS</b><br>Due to (or as a consequence of):<br><b>b. CARCINOMA OF AMPULLA OF VATER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Due to (or as a consequence of): |  |   |  |  |   |   |  | Approximate Interval Between Onset and Death<br><b>days</b>     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>COPD</b>  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
|  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28d. Describe how injury occurred   |  |   |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |   |   |  |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |   |  | 29c. License number<br><b>D38457</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 30, 1999</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N. W. [Signature] 1011 PRINCE PHILIP DR, OLNEY, MD 20832</b>  |  |   |  |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |   |  |   |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12100

|   |   |  |   |  |  |   |  |  |  |  |   |  |
|---|---|--|---|--|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Judith Kay Jewett   |  |   |  |  | 2. Date of Death<br>Month Day Year<br>March 26, 1999                |  |  | 3. Time of Death<br>12:40 PM   |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>6 Gardenia Court  |  |   |  |  | 4b. City, Town, or Location of Death<br>Gaithersburg                |  |  | 4c. County of Death<br>Montgomery  |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>438-62-9915  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>57 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Sept 2, 1941                                  |  | 9. Birthplace (State or Foreign Country)<br>Texas  |  |   |  |
|   | Usual Residence of Decedent   |  |   |  |  |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Gaithersburg  |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |
|   | 10e. Street and Number<br>6 Gardenia Court  |  |   |  | 10f. Zip Code<br>20879   |   | 10g. Citizen of What Country?<br>United States                                       |  |  |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>5  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher  |  |  |   | 16b. Kind of Business/Industry<br>High School  |  |  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>John Truman New  |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia Craig |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Radhika Rishi (daughter)  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2623 Deer Ridge Drive, Silver Spring, MD 20904  |   |  |  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  | Date<br>3-27-99  |   | 20c. Location - City or Town, State<br>Beltsville, Maryland                          |  |  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>Rapp Funeral Services, P.A.<br>933 Gist Avenue, Silver Spring, Maryland 20910  |   |  |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Metastatic Leiomyosarcoma<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |   |  |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br>5 1/2 years |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate. | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |  |  |  |  |   |  |
|   | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br>D43083  |   | 29d. Date signed (Month, Day, Year)<br>March 26, 1999                                |  |  |  |   |  |
| State Registrar   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>George A. Sotos, M.D., 9707 Medical Center Drive, #300, Rockville, Maryland 20850   |  |   |  |  |   |  |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br>MAR 29 1999  |  | 32. Registrar's Signature<br>   |  |  |   |  |  |  |  |   |  |



State of Maryland / Department of Health and Mental Hygiene 99 12101

## Certificate of Death

Reg. No.

**Division of Vital Records, P.O. Box 68760,**





99-1813-033

jhm

unk. 99-063 WENDELL L. JOHNSON

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State of Maryland / Department of Health and Mental Hygiene

99 12102

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |   |  |
|---|---|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Wendell Luvone Johnson  |  |   |   | 2. Date of Death<br>Month Day Year<br>MARCH 26, 1999   |  | 3. Time of Death<br>09:20 PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>PRINCE GEORGES HOSPITAL CENTER  |  |   |   | 4b. City, Town, or Location of Death<br>Cheverly   |  | 4c. County of Death<br>PRINCE GEORGES   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>217-66-0844  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>42 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>March 18, 1957 | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |  |
|   | Usual Residence of Decedent   |  |   |   |  |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland  | 10b. County<br>Prince Georges  | 10c. City, Town or Location<br>Capitol Heights  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
|   | 10e. Street and Number<br>714 Larchmont Drive   |  | 10f. Zip Code<br>20743  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (14 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Warehouse Foreman  |   | 16b. Kind of Business/Industry<br>Food Distributor   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Joseph Francis Johnson   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Magdalen Dotson  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mary M. Johnson/Mother  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>40004 New Market Turner Road, Mechanicsville, MD 20659  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Charles Memorial Gardens  |   | 20c. Date<br>4/5/99  |  | 20d. Location - City or Town, State<br>Leonardtwn, MD   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Michael K. Gardiner</i>   |  | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, MD 20650   |   |  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Multiple Injuries.</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |   | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Atherosclerotic cardiovascular disease</i>   |  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br>3-26-99  |   | 28b. Time of Injury<br>8:47 PM   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred<br><i>Pedestrian struck by Auto.</i>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><i>Roadway</i>  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><i>central Av + Ventura</i>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |   |  |
|   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br>OCME   |   | 29d. Date signed (Month, Day, Year)<br>MARCH 28, 1999  |  |   |  |
| State<br>Registrar                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>David R Fowler</i> 111 Penn Street, Baltimore, Maryland 21201  |  |   |   |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br>APR 2 1999   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12103

|  |  |                               |   |  |  |  |  |   |
|--|--|-------------------------------|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ada Miller Jung</b>                                 |                               |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>31</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>12 47 pm</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Fallston General Hospital</b> |                               |   |  | 4b. City, Town, or Location of Death<br><b>Fallston</b>  |  | 4c. County of Death<br><b>Harford</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-34-7177</b>  |                               | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 18, 1912</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |
|  | Usual Residence of Decedent  |                               |   |  |  |  |  |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b> |   | 10c. City, Town or Location<br><b>Abingdon</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>3807 B Memory Lane</b>  |  |                               |   | 10f. Zip Code<br><b>21009</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |                               |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Secretary</b>               |  |  | 16b. Kind of Business/Industry<br><b>State Health Department</b>                               |   |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Ellsworth Miller</b>   |  |                               |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Emma Miller</b>  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Walter G. Jung (son)</b>  |  |                               |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3001 Franklin Chance Dr., Fallston, Maryland 21047</b> |  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | Date<br><b>4/3/99</b>  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Stephen A. Hughes</i>  |  |                               |   | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>50 West Broadway Street, Bel Air, Maryland 21014</b>                   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>3 days</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |                               |   |  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                               |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|  |  |                               |   |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |  |                               |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                               | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |                               | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|  |  |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28d. Describe how injury occurred  |  |   |
|  |  |                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                               |   |  |  |  |  |   |
| 29b. Signature and title of certifier<br><i>Bashar Karakash, M.D.</i>  |  |                               |   | 29c. License number<br><b>D0047813</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 31 1999</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BASHAR KARAKASH 39 Churchville Rd Suite 200 Bel Air MD 21014</b>  |  |                               |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 6 1999</b>   |  |                               | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Jung Ada

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



10 Eldon James

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12104

|  |  |  |  |   |   |   |  |  |   |  |
|--|--|--|--|---|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Eldon Jerome James</b>                      |  |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>14</b> Year <b>1999</b> |   |  |  | 3. Time of Death<br><b>Approx 5:30 AM</b>             |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1905 Hawthorne Rd</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Edgewood</b>               |   |  |  | 4c. County of Death<br><b>HARFORD</b>                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-52-1387</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>MAY 15, 1947</b> |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |
|  | Usual Residence of Decedent  |  |  |   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>HARFORD</b>                              |  | 10c. City, Town or Location<br><b>Edgewood</b>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1905 Hawthorne Rd</b>   |  |   |   | 10f. Zip Code<br><b>21040</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1965-1985</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Photographer</b>  |   | 16b. Kind of Business/Industry<br><b>Photography</b>                    |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Elsworth James</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hortense Wainwright</b>   |   |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Vonnie James</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1905 Hawthorne Rd Edgewood MD 21040</b>   |   |   |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST James Cem.</b>  |   | Date<br><b>MAR 20</b>   |  | 20c. Location - City or Town, State<br><b>Hawthorne MD</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  |  |  | 22. Name and Address of Facility<br><b>BEARD Funeral Home<br/>552 Lewis St Hawthorne MD</b>   |   |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Terminal lung cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |   |   |   |  | Approximate Interval Between Onset and Death   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |  |  |  |   |   |   |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |  |  |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |  |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred                                       |  |  |   |  |
|  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   |   |  | 29c. License number<br><b>DO 9559</b>  |   |  |
|  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>3/17/99</b>   |   |   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>L. WATERBURY, MD. JTBHC 4940 EASTERN AVE. BALT. 21224</b>   |  |  |  |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 22 1999</b>  |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |   |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

|   |  |  |  |   |   |  |  |   |
|---|--|--|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE WILLIAM JOHNSON III</b>                      |  |  |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>27</b> Year <b>1999</b> |  | 3. Time of Death<br><b>10:44 AM</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Fallston General Hospital</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Fallston</b>               |  | 4c. County of Death<br><b>Harford</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-30-0812</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 4, 1932</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                 |
|   | Usual Residence of Decedent  |  |  |   |   |  |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Aberdeen</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>3122 James Run Road</b>  |  |  |  | 10f. Zip Code<br><b>21001</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1952-56</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Firefighter</b>   |   |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                                       |   |
| 17. Father's Name (First, Middle, Last)<br><b>George William Johnson Jr.</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Hicks Howell</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Johnson - wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3122 James Run Rd., Aberdeen, MD 21001</b>  |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Highview Memorial Grdns.</b>   |   | 20c. Location - City or Town, State<br><b>3/31/99 Fallston, Maryland</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Howard K. McComas</i>   |  |  |  | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Rd., Abingdon, MD 21009</b>  |   |  |  |   |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Idiopathic Cardiomyopathy</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>5yrs</b>                                 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|   |  |  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   |  |  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. Signature and title of certifier<br><i>Dr. R. E. ...</i>   |   | 29c. License number<br><b>D-16444</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 27th 1999</b>                               |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>VIJAY-S. NAIRM-D 2112 Belair Road. Fallston. MD 21047.</b>   |  |  |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Page 10. May 15, 1964

and approximately 1/2 mile from the shore. The water was very shallow and the bottom was composed of sand and shells. The tide was out and the water was very clear. The sky was blue and the sun was shining. The birds were flying overhead and the water was very calm. The tide was out and the water was very clear. The sky was blue and the sun was shining. The birds were flying overhead and the water was very calm.

Page 11. May 16, 1964

The tide was out and the water was very clear. The sky was blue and the sun was shining. The birds were flying overhead and the water was very calm.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |                                |  |  |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Gladys Gay Jones</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 22, 1999</b>  |                                | 3. Time of Death<br><b>12:41 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>  |                                | 4c. County of Death<br><b>Harford</b>  |  |
| 5. Social Security Number<br><b>229-26-1093</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>08-26-1927</b>                                       |  |
| 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  |   |  |  |                                |  |  |
| Usual Residence of Decedent  |  |   |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Havre de Grace</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>605 Lewis Street</b>  |  |   |  | 10f. Zip Code<br><b>21078</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b> College (1-4 or 5+) -----   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |                                | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Monroe Harrington</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lettie Esther Dunnavant</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kimerly A. Von Wahlde-Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>116 Starboard Court Perryville, MD 21903</b>   |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harford Mem. Gardens</b>   |  | Data<br><b>3-25-99</b>   |                                | 20c. Location - City or Town, State<br><b>Aberdeen, Maryland</b>                               |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Mitchell-Smith funeral Home P.A.<br/>123 S. Washington St. Havre de Grace, MD 21078</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiopulmonary Arrest</b><br>Due to (or as a consequence of):<br>b. <b>CHF COPD Pneumonia</b><br>Due to (or as a consequence of):<br>c. <b>COPD</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>{<br>Approximate Interval Between Onset and Death<br>minutes<br>weeks<br>years |  |   |  |  |                                |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>20053622</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3-23-99</b>                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stefan Eltgroth, M.D. 319 South Union Ave. Havre de Grace, MD 21078</b>   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 25 1999</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12107

Amend. 5 4/6/99 SM AACO Health

Certificate of Death

Reg. No.

|  |   |   |  |  |  |   |  |  |  |  |
|--|---|---|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Marilyn Jean Jackson                              |   |  |  | 2. Date of Death<br>Month Day Year<br>March 28, 1999 |   |  |  | 3. Time of Death<br>6:40 am                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center |   |  |  | 4b. City, Town, or Location of Death<br>Annapolis    |   |  |  | 4c. County of Death<br>Anne Arundel              |  |
| Funeral<br>Director  | 5. Social Security Number<br>28-0645<br>272-26-2928   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>65 Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br>June 25, 1933 |  | 9. Birthplace (State or Foreign Country)<br>Ohio |  |
|  | Usual Residence of Decedent   |   |  |  |  |   |  |  |  |  |
| 10a. State<br>MD   |   | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Arnold  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>1241 Tamarac Trail   |   |   |  | 10f. Zip Code<br>21012   |  |   |  | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Registered Nurse  |  |   |  | 16b. Kind of Business/Industry<br>Medical  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Raleigh N. Taylor   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carrie McCullough   |  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>William C. Jackson / husband   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1241 Tamarac Trail, Arnold, MD 21012  |  |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory   |  | Date<br>Mar 29 1999  |  | 20c. Location - City or Town, State<br>Baltimore, MD  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>▶ <i>[Signature]</i>  |   |   |  | 22. Name and Address of Facility<br>Barranco & Sons, P.A. Severna Park Funeral Home<br>495 Gov. Ritchie Hwy., Severna Park, MD 21146   |  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Bladder Cancer<br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>1 1/2 yrs.   |   |   |  |  |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |   |  |  |  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                    |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>▶ <i>[Signature]</i>  |   |   |  | 29c. License number<br>019838  |  |   |  | 29d. Date signed (Month, Day, Year)<br>3/28/99   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Stuart E. Selouch, M.D. 900 Bestgate Rd. Annapolis Md. 21401   |   |   |  |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 30 1999   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #14,3/31/99,BMW, Montg.Co.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIJAYA R. KANNAN

2. Date of Death

Month  
MARCHDay  
28Year  
1999

3. Time of Death

2.12 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

213-29-5453

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 21, 1930

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State  
Maryland  
10b. County  
Montgomery

10c. City, Town or Location

North Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14433 Settlers Landing Way

10f. Zip Code

20878

10g. Citizen of What Country?

India

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify: ~~White~~ Asian

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Certified Public Accountant

16b. Kind of Business/Industry

Government of  
India

17. Father's Name (First, Middle, Last)

T.D. Vijayaragavan

18. Mother's Name (First, Middle, Maiden Surname)

Thankam None

19a. Informant's Name/Relationship (Type, Print)

Kesavan Kannan/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14433 Settlers Landing Way, N. Potomac, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Montgomery Crematorium, Inc.  
March 29, 1999

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. SEPSIS

Due to (or as a consequence of):

2 WEEKS

b. PNEUMONIA

Due to (or as a consequence of):

2 WEEKS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. METASTATIC PROSTATE CANCER

Due to (or as a consequence of):

3 MONTHS

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Medical Certification: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

AJIT P. KURUVILLA, M.D., 11125 ROCKVILLE PIKE, #305, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
**Certificate of Death**

Reg. No.

99 12109

**Physician  
/Medical  
Examiner**

**Funeral  
Director**

|  |  |   |  |  |                                |  |  |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Kathryn June Kapsch</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 25, 1999</b>  |                                | 3. Time of Death<br><b>7:00 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>15220 Dufief Drive</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>North Potomac</b>   |                                | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>226-58-2444</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>September 27, 1943</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |  |   |  |  |                                |  |  |
| Usual Residence of Decedent  |  |   |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>North Potomac</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>15220 Dufief Drive</b>  |  |   |  | 10f. Zip Code<br><b>20878</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>4</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Director of Human Resources</b>  |                                | 16b. Kind of Business/Industry<br><b>Hotel Management</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Wilbur A. Schmidt</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>June Wood</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert J. Kapsch / husband</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15220 Dufief Drive, North Potomac, Maryland 20878</b>                                    |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |  | Date<br><b>March 30, 1999</b>  |                                | 20c. Location - City or Town, State<br><b>Rockville, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Barbara J. McMullen Lawrence</b> M00831  |  |   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Rockville, Inc.<br/>300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>                                    |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Amyotrophic Lateral Sclerosis</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                |  |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><b>John J. Kelly, Jr.</b>   |  |   |  | 29c. License number<br><b>19267</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>March 28, 1999</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John J. Kelly, Jr., M.D. 2150 Pennsylvania Ave., NW Washington, D.C. 20037-2396</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>  |  |   |  | 32. Registrar's Signature<br><b>Beverly B. Sparks</b>  |                                |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

50







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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12110

|  |   |   |   |   |   |  |   |  |
|--|---|---|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HELEN FRANCES KENNAN</b>   |   |   |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>27</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>5:05 PM</b>  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-40-7130</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 24, 1943</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Poolesville</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>19813 Spurrier Avenue</b>  |   | 10f. Zip Code<br><b>20837</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |   | 16a. Kind of Business/Industry<br><b>Waste Industry</b>   |   | 16b. Kind of Business/Industry<br><b>Waste Industry</b>   |  | 16c. Kind of Business/Industry<br><b>Waste Industry</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Harold Lutz</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucille Custer</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jeffery Fink, Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20878 704 Quince Orchard Blvd., #2011 Gaithersburg, MD</b> |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Boyd's Presbyterian Cem.</b>   |   | 20c. Location - City or Town, State<br><b>Boyd's, Maryland</b>  |  | 20d. Date<br><b>Mar 30, 1999</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b>   |   | 22. Name and Address of Facility<br><b>10 East Deer Park Dr., Gaithersburg, MD 20877</b>  |  | 22. Name and Address of Facility<br><b>10 East Deer Park Dr., Gaithersburg, MD 20877</b>  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Chronic Obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death<br><b>10 yrs</b>   |   |   |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No          |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  |
|  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>David A Holden MD</i> |   | 29c. License number<br><b>047791</b>            |   | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1999</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David Holden MD 809 Veirs Mill Rockville MD 20851</b>   |   | 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>           |   | 32. Registrar's Signature<br><i>[Signature]</i> |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12111

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner               | 1. Decedent's Name (First, Middle, Last)<br><b>NADINE GOINS KELLER</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 31, 1999</b>  |  | 3. Time of Death<br><b>9:30 A.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>22680 CEDAR LANE COURT APT. # 1109</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>LEONARDTOWN</b>   |  | 4c. County of Death<br><b>ST. MARY'S</b>  |  |
| Funeral<br>Director                             | 5. Social Security Number<br><b>408-26-0175</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 7, 1920</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>   |  | Usual Residence of Decedent   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>ST. MARY'S</b>  |  |
| To Be Completed by Funeral Director             | 10c. City, Town or Location<br><b>LEONARDTOWN</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>22680 CEDAR LANE COURT APT. # 1109</b>  |  | 10f. Zip Code<br><b>20650</b>   |  |
|   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |
| To Be Completed by Physician/Medical Examiner   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5TH</b> College (1-4 or 5+) <b>-</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOE COLLINS</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LILLY GOINS</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>BRENDA J. WINDSOR / DAUGHTER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27117 DOGWOOD LANE MECHANICSVILLE, MD. 20659</b>  |  |
| Physician<br>/Medical<br>Examiner               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FT. LINCOLN CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>4/6/99 BLADENSBURG, MD.</b>  |  | 21. Signature of Funeral Service Licensee<br><b>DAVID A. GOFF</b> MO1095  |  |
|   | 22. Name and Address of Facility<br><b>3035 OLD WASHINGTON ROAD HUNTT FUNERAL HOME, INC. WALDORF, MD. 20604</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of): |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |
| To Be Completed by Physician/Medical Examiner   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |
|   | 29c. License number<br><b>D19917</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/31/99</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES C. BOYD, M.D., P.O. BOX 730, HOLLYWOOD, MARYLAND 20636</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 02 1999</b>   |  |
| 32. Registrar's Signature<br><b>[Signature]</b> |   |  |   |  |  |  |   |  |

ORIGINAL




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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12112

|  |  |  |  |  |   |   |  |  |
|--|--|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ABRAHAM T. KAMINKOW</b>                               |  |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 18, 1999</b> |   | 3. Time of Death<br><b>7:45 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>       |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-09-9134</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>12/16/1918</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>      |
|  | Usual Residence of Decedent  |  |  |  |   |   |  |  |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Fallston</b>   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2933 Charles Street</b>   |  |  |  | 10f. Zip Code<br><b>21047</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Caucasian</b>                    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Display Decorator</b>  |   |   | 16b. Kind of Business/Industry<br><b>Clothing</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Max Kaminkow</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Kirshman</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph T. Kaminkow/Son</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2931 Charles Street Fallston, Md. 21047</b>  |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Highview Mem. Garden</b>  |   | 20c. Location - City or Town, State<br><b>1999 Fallston, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>E.G. Kurtz &amp; Son Funeral Home, P.A.<br/>Jarrettsville, Maryland</b>   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>VENTRICULAR ARRHYTHMIA</b><br><br>Due to (or as a consequence of):<br><b>ISCHEMIC HEART DISEASE</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |   |   |  | Approximate Interval Between Onset and Death<br><b>IMMEDIATE</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MULTIPLE DECUBITUS</b><br><b>CEREBRAL THROMBOSIS</b>  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred                                |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>                                   |  | 29c. License number<br><b>D41410</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 18th, 1999</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOGINDER P. MEHTA, M.D., 7601 OSLER ROAD, TOWSON, MARYLAND 21204</b>  |  |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 24 1999</b>  |  |  |  | 32. Registrar's Signature<br>  |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Mr. J. H. ...

Mr. J. H. ...

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12113

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NELLIE ELIZABETH KELL

2. Date of Death

MARCH 31, 1999

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HARFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

HDEG

4c. County of Death

HARFORD

5. Social Security Number

230-20-7716

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-28-03

9. Birthplace (State or Foreign Country)

HARFORD

Usual Residence of Decedent

10a. State  
MD

10b. County

HARFORD

10c. City, Town or Location

HICKORY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1507 BLUE HOUSE CT

10f. Zip Code

21154

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

BLACK

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Keeper

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

John Garrett

18. Mother's Name (First, Middle, Maiden Surname)

Matilda Williams

19a. Informant's Name/Relationship (Type, Print)

Horace Tittle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1507 Blue House CT Street MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Clarks United

Date

4-3-99

20c. Location - City or Town, State

Bethesda MD

21. Signature of Funeral Service Licensee

Rita Smith

22. Name and Address of Facility

Bethesda Funeral Home  
Home of Grace MD 20878

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intractable Congestive Heart Failure

Due to (or as a consequence of):

b. Cardiomyopathy with Ejection Fraction

Due to (or as a consequence of):

c. of 20-30 percent

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

coupled days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial Fibrillation

Aspiration Pneumonitis

Chronic Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Subacute Care

27. Manner of Death

1 ☒ Natural 2 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Manuel M. Lazatin MD

29c. License number

D19583

29d. Date signed (Month, Day, Year)

April 1, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MANUEL M. LAZATIN MD

8 Law Street, Aberdeen, Maryland 21001

31. Date filed (Month, Day, Year)

APR 9 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



1945-1946  
1947-1948  
1949-1950

1951-1952  
1953-1954  
1955-1956

1957-1958  
1959-1960  
1961-1962

1963-1964  
1965-1966  
1967-1968

1969-1970  
1971-1972  
1973-1974

1975-1976  
1977-1978  
1979-1980

1981-1982  
1983-1984  
1985-1986



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12114

|  |   |                              |   |   |  |   |   |  |
|--|---|------------------------------|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CAMILLA KEATING</b>                                |                              |   |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 26 1999</b>   |   | 3. Time of Death<br><b>5:10 PM</b>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>LAUREL REGIONAL HOSPITAL</b> |                              |   |   | 4b. City, Town, or Location of Death<br><b>COLUMBIA</b>  |   | 4c. County of Death<br><b>HOWARD</b>                                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>302-58-9019</b>   |                              | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>DEC 11, 1916</b>              | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>  |
|  | Usual Residence of Decedent   |                              |   |   |  |   |   |  |
| 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>HOWARD</b> |   | 10c. City, Town or Location<br><b>COLUMBIA</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 10e. Street and Number<br><b>10421 SCHOOL MASTER PLACE</b>   |   |                              |   | 10f. Zip Code<br><b>21044</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>   |   |                              |   | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TEACHER</b>   |  | 16b. Kind of Business/Industry<br><b>EDUCATION</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>MICHAEL B. DONOVAN</b>   |   |                              |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BRIDGET SWEENEY</b>   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>GERALD KEATING/SON</b>  |   |                              |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10421 SCHOOL MASTER PLACE, COLUMBIA, MD 21044</b>   |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                              |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. JOSEPH CEMETERY</b>  |  | Date<br><b>MARCH</b>  |   | 20c. Location - City or Town, State<br><b>CONNELLSVILLE, PA</b>  |
| 21. Signature of Funeral Service Licensee<br><i>Douglas D. Hafner</i>  |   |                              |   | 22. Name and Address of Facility<br><b>HAFFER FUNERAL HOME</b><br><b>1302 NATIONAL HWY, LAVALE, MD 21502</b>  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><b>Respiratory Failure</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br><b>Hypertension</b> |   |                              |   |   |  |   |   | Approximate Interval Between Onset and Death<br><b>3 days</b><br><b>3 days</b><br><b>3 days</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                              |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|  |   |                              |   |   |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                              |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |                              |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |                              |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                              |   | 29b. Signature and title of certifier<br><i>Douglas D. Hafner</i> attending   |  | 29c. License number<br><b>042580</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3-27-99</b>  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>P.S. ACOSTA MD 5632 Annapolis Rd #13 BRADGAS BULK MD 20710.</b>   |   |                              |   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>  |   |                              |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12115

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last) **Ferdinand Francis Larkin** 2. Date of Death Month **March** Day **26** Year **1999** 3. Time of Death **10:30AM**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **Manor Care** 4b. City, Town, or Location of Death **Silver Spring** 4c. County of Death **Montgomery**

5. Social Security Number **143-54-9342** 8. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **51** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Dec. 23, 1947** 9. Birthplace (State or Foreign Country) **New Jersey**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Montgomery** 10c. City, Town or Location **Silver Spring** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **2501 Musgrove Rd.** 10f. Zip Code **20904** 10g. Citizen of What Country? **U.S.A**

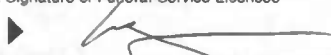
11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedant Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **12** College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Not Applicable** 16b. Kind of Business/Industry **Not Applicable**

17. Father's Name (First, Middle, Last) **Ferdinand Francis Larkin Sr.** 18. Mother's Name (First, Middle, Maiden Surname) **Florence Gallaher**

19a. Informant's Name/Relationship (Type, Print) **Mary Ann Larkin-Sister** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **301 Cavalier Court, Silver Spring, MD 20901**

20a. Method of Disposition ☒ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **St. Mary's Cemetery** Date **3-31-99** 20c. Location - City or Town, State **Bellmawr, NJ**

21. Signature of Funeral Service Licensee  22. Name and Address of Facility **National Funeral Home, 7400 Lee Highway Falls Church, VA 22042**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **a. Aspiration Pneumonia** Due to (or as a consequence of): **b. Seizures** Due to (or as a consequence of): **c. Down's syndrome** Due to (or as a consequence of): **d. Dec. Ulcer - sacral area** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {


Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No


25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  **Kiet Vohra M.D.** 29c. License number **D20274** 29d. Date signed (Month, Day, Year) **3/26/99**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Dr. Kiet Vohra 1299 Lamberton Drive Silver Spring, MD 20902**

31. Date filed (Month, Day, Year) **APR 01 1999** 32. Registrar's Signature 

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

12

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12116

|   |   |  |   |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
|---|---|--|---|---|--|--|--|--|--|---|----|----------------------|--|----------------------------------|--|----|--|----------------------------------|--|----|--|--|----------------------------------|--|--|----|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>LILLIAN BELL LASCHALT                             |  |   |   | 2. Date of Death<br>Month Day Year<br>MARCH 30, 1999   |  |  |  | 3. Time of Death<br>10:40 A.M.                         |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>MONTGOMERY GENERAL HOSPITAL |  |   |   | 4b. City, Town, or Location of Death<br>OLNEY  |  |  |  | 4c. County of Death<br>MONTGOMERY                      |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>219-48-2213  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>90 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>SEPT. 6, 1908 |  | 9. Birthplace (State or Foreign Country)<br>NEW JERSEY |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   | Usual Residence of Decedent   |  |   |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 10a. State<br>MARYLAND  |   | 10b. County<br>MONTGOMERY  |   | 10c. City, Town or Location<br>SILVER SPRING  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 10e. Street and Number<br>13315 DAUPHINE STREET   |   |  |   | 10f. Zip Code<br>20906  |  |  |  | 10g. Citizen of What Country?<br>UNITED STATES   |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 0  |   |  |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER  |  |  |  | 16b. Kind of Business/Industry<br>HOME   |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br>JOHN BELL  |   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY HAMILTON   |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>MARILYN L. DILDAY - DAUGHTER  |   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6818 REDBERRY ROAD, CLARKSVILLE, MARYLAND 21029   |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ARLINGTON NATIONAL CEMETERY 4-13-99 ARLINGTON, VA   |  |  |  | 20c. Location - City or Town, State  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |   |   | 22. Name and Address of Facility<br>HINES-RINALDI FUNERAL HOME, INC.<br>11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |   |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>CHLORALHYDROXYMETHYL</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/>8 DAYS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |   |  |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | CHLORALHYDROXYMETHYL | Approximate Interval Between Onset and Death<br>8 DAYS | Due to (or as a consequence of): |  | b. |  | Due to (or as a consequence of): |  | c. |  |  | Due to (or as a consequence of): |  |  | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.  | CHLORALHYDROXYMETHYL   | Approximate Interval Between Onset and Death<br>8 DAYS  |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   | Due to (or as a consequence of):  |  |   |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   | b.  |  |   |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   | Due to (or as a consequence of):  |  |   |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| c.  |   |  |   |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| Due to (or as a consequence of):  |   |  |   |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| d.  |   |  |   |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CITRAZOLAM LYMPHOCYTE DEFECTIVE<br>SEVERE OSTEOARTROSIS   |   |  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br>025947  |  | 29d. Date signed (Month, Day, Year)<br>MARCH 30, 1999  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Barbara J. Sparks, 5540 TEN OAKS RD CLARKSVILLE MD 21029  |   |  |   |   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999  |   |  |   | 32. Registrar's Signature<br>   |  |  |  |  |  |   |    |                      |  |                                  |  |    |  |                                  |  |    |  |  |                                  |  |  |    |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12117

|   |  |  |  |   |  |   |  |   |
|---|--|--|--|---|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Rashad Robert Lee</b>   |  |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1999</b>  |   | 3. Time of Death<br><b>2105</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland Medical System</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>Baltimore City</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-51-7372</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>1</b> Yrs.   | If Under 1 Year<br>Months <b>1</b> Days <b>25</b>  | If Under 24 Hrs.<br>Hours <b>1</b> Min. <b>25</b> | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 29, 1998</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
|   | Usual Residence of Decedent  |  |  |   |  |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Anne Arundel</b>                   |  | 10c. City, Town or Location<br><b>Glen Burnie</b> |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>400 Glenwood Avenue</b>   |  |  |   | 10f. Zip Code<br><b>21061</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>  |   | 16b. Kind of Business/Industry<br><b>N/A</b>   |   |  |   |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Reginald Lee</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Patricia Sumpter</b>   |   |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Reginald Lee (Father)</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>400 Glenwood Ave., Glen Burnie, MD 21061</b>   |   |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Locust Church Cem.</b>  |   | Date<br><b>4/1/99</b>  |   | 20c. Location - City or Town, State<br><b>Simpsonville, MD</b>                                 |   |
|   | 21. Signature of Funeral Service Licensee<br><i>George R. Snowden</i>  |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>  |   |  |   |  |   |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <b>Trisomy 18</b><br>Due to (or as a consequence of):<br>b. <b>Ventricular Septal Defect</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>14 months</b><br><b>14 months</b>  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| State Registrar   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |   |  |   |  |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |   |
|   | 29b. Signature and title of certifier<br><i>Wesley Ruffin MD</i>   |  |  |   | 29c. License number<br><b>DD054280</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 26 1999</b>                                    |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John Wesley Ruffin MD 22 South Greene St Baltimore, MD 21201</b> |  |  |  |   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |  | 32. Registrar's Signature<br><i>Benita G. Sparks</i> |  |   |  |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12118

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LESTER M. LEWIS

2. Date of Death

03.25.1999

Day

Year

3. Time of Death

12:51 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

578.18.5198

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01.02.1920

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

CHEVY CHASE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4601 NORTH PARK AVENUE #1608

10f. Zip Code

20815

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CIVIL ENGINEER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

WILLIAM LEWIS

18. Mother's Name (First, Middle, Maiden Surname)

DAISY MARX

19a. Informant's Name/Relationship (Type, Print)

CHARLOTTE K. LEWIS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4601 N. PARK AVE #1608, CHEVY CHASE, MD 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WASHINGTON HEBR. CON. MP 3.29.99 WASHINGTON, DC

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

IMMEDIATE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

YEARS

Due to (or as a consequence of):

c. CARDIOMYOPATHY

YEARS

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35293

29d. Date signed (Month, Day, Year)

March 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATHERINE F MCCOY MD

BETHESDA, MD 20814 8600 OLD GEORGETOWN ROAD

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

B. Sparks

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12119

|   |  |                                  |   |   |  |  |   |  |   |   |  |
|---|--|----------------------------------|---|---|--|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ANTOINETTE H. LIBSTER</b>                 |                                  |   |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 26, 1999</b>  |  |   |  | 3. Time of Death<br><b>2:20 PM</b>                                |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>12923 DEAN ROAD</b> |                                  |   |   | 4b. City, Town, or Location of Death<br><b>WHEATON</b>   |  |   |  | 4c. County of Death<br><b>MONTGOMERY</b>                          |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>290-28-2965</b>  |                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 14, 1924</b> |  | 9. Birthplace (State or Foreign Country)<br><b>CZECHOSLOVAKIA</b> |   |  |
|   | Usual Residence of Decedent  |                                  |   |   |  |  |   |  |   |   |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>MONTGOMERY</b> |   | 10c. City, Town or Location<br><b>WHEATON</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |
| 10e. Street and Number<br><b>12923 DEAN ROAD</b>  |  |                                  |   | 10f. Zip Code<br><b>20906</b>   |  |  |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>  |  |                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  |  |   | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>MOSES HELLER-BILLET</b>   |  |                                  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MALKA RINDLER-INTRATOR</b> |   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LEONARD LIBSTER (HUSBAND)</b>  |  |                                  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12923 DEAN ROAD - WHEATON, MARYLAND 20906</b>   |  |  |   |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JUDEAN MEMORIAL GARDENS</b>  |  | 20c. Date<br><b>3/29/99</b>  |   | 20d. Location - City or Town, State<br><b>OLNEY, MARYLAND</b>  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Donald C. Stettin</b>   |  |                                  |   | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852</b>  |  |  |   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Chronic obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |                                  |   |   |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>15 years</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pancreatitis</b>   |  |                                  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |                                  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
|   |  |                                  |   | 28d. Describe how injury occurred   |  |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                  |   | 29b. Signature and title of certifier<br><b>Dr. Weiner MD</b>   |  |  |   | 29c. License number<br><b>024571</b>   |   |   |  |
|   |  |                                  |   | 29d. Date signed (Month, Day, Year)<br><b>March 28, 1999</b>  |  |  |   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Jay Weiner MD 11501 Georgia Ave Wheaton, Md</b>  |  |                                  |   |   |  |  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |  |                                  |   | 32. Registrar's Signature<br><b>Beverly B. Sparks</b>   |  |  |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12120

## Certificate of Death

Reg. No.

|  |  |  |   |   |  |  |  |  |  |
|--|--|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Sidney Liebgold  |  |   |   | 2. Date of Death<br>Month Day Year<br>March 27, 1999   |  | 3. Time of Death<br>11:25 PM                                     |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Shady Grove Adventist Hospital   |  |   |   | 4b. City, Town, or Location of Death<br>Rockville  |  | 4c. County of Death<br>Montgomery                                |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>071-30-0410   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F             | 7. Age (In yrs. last birthday)<br>97 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Nov. 3, 1901  |  | 9. Birthplace (State or Foreign Country)<br>New York, NY   |  |
|  | Usual Residence of Decedent  |  |   |   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   | 10b. County<br>Montgomery  | 10c. City, Town or Location<br>Gaithersburg   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
|  | 10e. Street and Number<br>9713 Inaugural Way   |  |   | 10f. Zip Code<br>20879  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College Administrator                |   | 16b. Kind of Business/Industry<br>City College - Chemistry Department  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Samuel Liebgold   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Hattie Siegal   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Susan Beth Smith - Granddaughter   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3179 N. Beachwood Drive Los Angeles, CA 90068   |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Beth David Cemetery   |   | Data<br>March 30, 1999   |  | 20c. Location - City or Town, State<br>Elmont, New York          |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Allen W. Dove</i>  |  |   |   | 22. Name and Address of Facility<br>Metropolitan Funeral Service, Inc.<br>5517 Vine Street Alexandria, VA 22310  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>pneumonia</i><br>Due to (or as a consequence of):<br>b. <i>Acute Renal failure</i><br>Due to (or as a consequence of):<br>c. <i>Congestive Heart Failure</i><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   | Approximate Interval Between Onset and Death<br>1 week<br>2 days<br>years  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |  |
|  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred  |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   | 29b. Signature and title of certifier<br><i>Stephen</i>   |  |  |  | 29c. License number<br>45843   |  |
|  |  |  |   | 29d. Date signed (Month, Day, Year)<br>March - 28th 1999  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>SAMEH ALY 481 N. Frederick Ave. #230 Gaithersburg MD 20877   |  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 31 1999   |  |  |   | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

12121

|  |  |   |   |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>DOROTHY J. LITTLE                          |   |   |  | 2. Date of Death<br>Month Day Year<br>MARCH 26, 1999   |  | 3. Time of Death<br>2:30 PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>FRIENDS NURSING HOME |   |   |  | 4b. City, Town, or Location of Death<br>SANDY SPRING   |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director  | 5. Social Security Number<br>053 24 9939   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>100 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>SEPT. 12, 1898  | 9. Birthplace (State or Foreign Country)<br>ILLINOIS   |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |  |
| 10a. State<br>MD.  |  | 10b. County<br>MONTGOMERY   |   | 10c. City, Town or Location<br>SANDY SPRING  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>17340 QUAKER LANE  |  |   |   | 10f. Zip Code<br>20860   |  | 10g. Citizen of What Country?<br>UNITED STATES                                       |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>TEACHER |  |  | 16b. Kind of Business/Industry<br>EDUCATION  |  |
| 17. Father's Name (First, Middle, Last)<br>RILEY M. LITTLE   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>NANCY M. CHAMBERLIN   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>NANCY A. MILLOY, NIECE   |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9419 ROSEHILL DRIVE, BETHESDA, MD. 20817  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>METROPOLITAN CREMATORY  |  | Date<br>3/27/99  |  | 20c. Location - City or Town, State<br>ALEXANDRIA, VA.   |  |
| 21. Signature of Funeral Service Licensee<br>Muriel H. Barber  |  |   |   |  | 22. Name and Address of Facility<br>MURIEL H. BARBER FUNERAL HOME<br>P.O. BOX 5038, LAYTONSVILLE, MD. 20882  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Hypostatic PNEUMONIA<br>Due to (or as a consequence of):<br>Cerebral ARTERIOSCLEROSIS<br>A.S.C.U.D.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  | Approximate Interval Between Onset and Death<br>TERM.<br>5 yrs<br>4 yrs  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner  |  | 29b. Signature and title of certifier<br>Donald R. Lewis M.D.   |   |  |  |  |  |  |
| 29c. License number<br>D06406  |  | 29d. Date signed (Month, Day, Year)<br>MARCH 26, 1999   |   |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DONALD R. LEWIS M.D. 4000 RT 108 OLNEY, MD 20832   |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 29 1999   |  | 32. Registrar's Signature<br>B. Sparks  |   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12122

|   |   |  |   |  |   |  |  |  |  |   |  |
|---|---|--|---|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Mary Margaret Logan                       |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br>March 30 1999                                  |  | 3. Time of Death<br>12:00 noon   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital |  |   |  |   |  | 4b. City, Town, or Location of Death<br>Silver Spring                                |  | 4c. County of Death<br>Montgomery  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>577-28-1127  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>78 Yrs. |  | 8. Date of Birth (Month, Day, Year)<br>Feb 27 1921                                   |  | 9. Birthplace (State or Foreign Country)<br>MD   |   |  |
|   | Usual Residence of Decedent   |  |   |  |   |  |  |  |  |   |  |
| 10a. State<br>MD  |   |  | 10b. County<br>Montgomery   |  |   | 10c. City, Town or Location<br>Silver Spring   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br>10209 Day Avenue  |   |  |   |  |   | 10f. Zip Code<br>20910   |  | 10g. Citizen of What Country?<br>USA   |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>1   |   |  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Purchasing Agent  |  |  | 16b. Kind of Business/Industry<br>Montgomery Wards   |   |  |
| 17. Father's Name (First, Middle, Last)<br>John Coates  |   |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sophie Lee  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Thomas M. Logan, Sr. /Husband   |   |  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10209 Day Avenue, Silver Spring, MD 20910   |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parklawn Memorial Park  |  |   | Date<br>4-3-99   |  | 20c. Location - City or Town, State<br>Rockville, MD   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>Anchew J. Cole   |   |  |   |  |   | 22. Name and Address of Facility<br>Collins Funeral Home<br>500 University Blvd, West, Silver Spring, MD 20901   |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cerebral Nervous System Bleed Due to (or as a consequence of):<br>b. Thyroid Gland Problem Due to (or as a consequence of):<br>c. Acute Myocardial Infarction Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br>2 days<br>3 mo. |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |
|   |   |  |   |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
|   |   |  |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
|   |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  | 29b. Signature and title of certifier<br>Stanley A. Schwartz MD   |  |   | 29c. License number<br>D17368  |  | 29d. Date signed (Month, Day, Year)<br>01/01/99  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Stanley A. Schwartz MD 5454 Wisconsin Ave Bethesda MD 20815   |   |  |   |  |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999  |   |  | 32. Registrar's Signature<br>B. Sparks  |  |   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12123

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Raymond Everett Lyons                                |   |  |  | 2. Date of Death<br>Month Day Year<br>March 26, 1999 |  | 3. Time of Death<br>13:25  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>7 Perennial Drive P.O. Box 334 |   |  |  | 4b. City, Town, or Location of Death<br>Earleville   |  | 4c. County of Death<br>Cecil   |  |
| Funeral<br>Director  | 5. Social Security Number<br>508-05-7298   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>82   | If Under 1 Year<br>Months Days                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>8/5/1916  | 9. Birthplace (State or Foreign Country)<br>Iowa         |
|  | Usual Residence of Decedent  |   |  |  |  |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Cecil  |  | 10c. City, Town or Location<br>Earleville  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>7 Perennial Drive P.O. Box 334   |  |   |  | 10f. Zip Code<br>21919   |  | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1941-1945   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Salesperson   |  | 16b. Kind of Business/Industry<br>Sales Western Ware   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Everett Lyons   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Leoline Smith   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Ruth Thompson Lyons  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7 Perennial Drive P.O. Box 334 Earleville, Md. 21919  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Evergreen Cemetery  |  | Date<br>3/30/99  |  | 20c. Location - City or Town, State<br>Wilson, NC  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>Fellows Helfenbein Newnam Funeral Home PA<br>Cecilton, Maryland  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Cardiomyopathy</u><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>10 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Non-Insulin Dependent Diabetes mellitus</u>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                        |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D15314  |  | 29d. Date signed (Month, Day, Year)<br>March 28, 1999  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>H Furkas, MD VNA/Northern Chesapeake Hospice, Elkton, MD   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8+1

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12124

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Rose R. Luddeke</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 22, 1999</b>  |  | 3. Time of Death<br><b>2138 Hrs.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital &amp; Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |  | 4c. County of Death<br><b>Allegany</b>   |  |
| 5. Social Security Number<br><b>214-05-8065</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 5, 1908</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Allegany</b>   |  | 10c. City, Town or Location<br><b>Cumberland</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>816 Roethe Avenue</b>  |  | 10f. Zip Code<br><b>21502</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Jewish</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Home</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Max Finkelson</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jennie Coppersmith</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Arthur Friedland/Nephew</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>935 Dingle Park Dr. Cumberland, Md. 21502</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>East View Cemetery</b>   |  | Date<br><b>March 24, 1999</b>  |  | 20c. Location - City or Town, State<br><b>Cumberland, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Ernest A. Riley, Jr.</b>   |  |   |  | 22. Name and Address of Facility<br><b>Leasure-Stein Funeral Home 230 Baltimore Avenue<br/>Cumberland, Md. 21502</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>30 YEARS</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |   |  | 29c. License number<br><b>012779</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/25/99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Guy W. Fiscus, M.D. 500 Memorial Ave. Cumberland, Md. 21502</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 26 1999</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

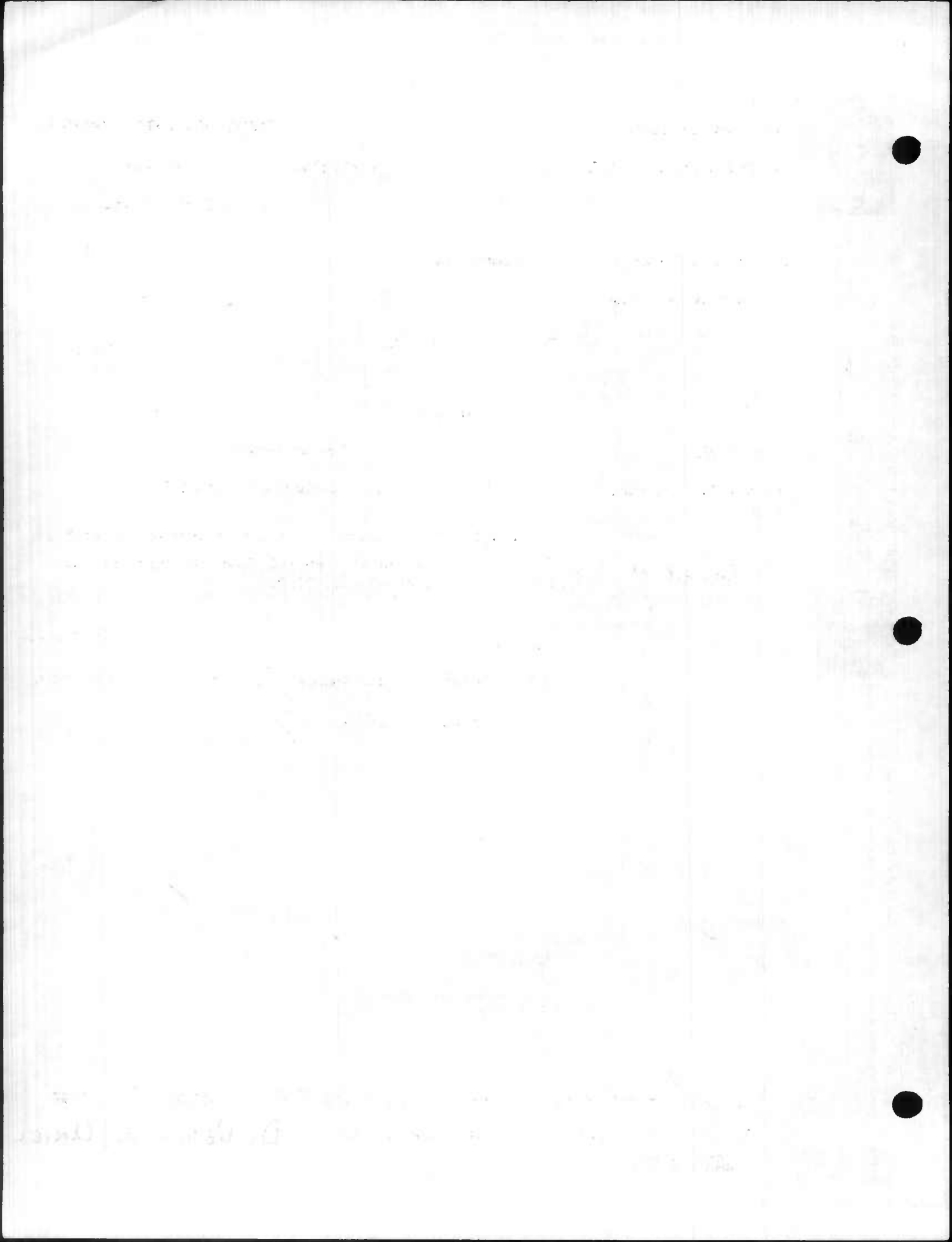
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

LUDEKE, ROSE F SS # 214 05 8065 DATE OF DEATH MARCH 22 1999



Reg. No.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 12126

|  |  |   |  |  |   |  |  |  |  |
|--|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>PATRICK KENNY LOGSDON</b>                   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 24, 1999</b> |  | 3. Time of Death<br><b>4:00 p.m.</b>                       |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>151 BOWERY STREET</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>FROSTBURG</b>    |  | 4c. County of Death<br><b>ALLEGANY</b>                     |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215 36 8968</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 2, 1936</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                |   | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ALLEGANY</b>                              |  | 10c. City, Town or Location<br><b>FROSTBURG</b>            |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>151 BOWERY STREET</b>   |   | 10f. Zip Code<br><b>21532</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b> |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>UNION REPRESENTATIVE</b>  |  | 16b. Kind of Business/Industry<br><b>STEEL, GLASS &amp; CERAMIC</b>  |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>DANIEL LOGSDON</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MAE BARRY</b>  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SALLY LOGSDON / WIFE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>151 BOWERY ST., FROSTBURG, MD 21532</b>  |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FROSTBURG MEMORIAL PARK</b>  |  | Date<br><b>3/27/99</b>   |   | 20c. Location - City or Town, State<br><b>FROSTBURG, MD 21532</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Alan M. Spowers</i>  |  |   |  | 22. Name and Address of Facility<br><b>SOWERS FUNERAL HOME, P.A.<br/>60 W. MAIN ST., FROSTBURG, MD 21532</b>   |   |  |  |  |  |
| 23a. Pertinent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Endstage Metastatic Lung Carcinoma 4 yrs</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred            |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D22181</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>03-27-99</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GARY L. WAGONER, M.D., 925 BISHOP WALSH DRIVE, CUMBERLAND, MD 21502</b>   |  |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM EARLE LENNON JR

2. Date of Death

Month Day Year  
March 26 1999

3. Time of Death

0725

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENNINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

220-28-1647

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 26, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

914 Loch Raven Rd.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Air Force

Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Career Air Force

16b. Kind of Business/Industry

Military

17. Father's Name (First, Middle, Last)

William Earle Lennon Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Glover

19a. Informant's Name/Relationship (Type, Print)

Dorothy V. Lennon/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

914 Loch Raven Rd., Salisbury, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

3/29/99

20c. Location - City or Town, State

Hurlock, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 2180423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)e. Anoxic encephalopathy  
Due to (or as a consequence of):Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. COPD  
Due to (or as a consequence of):  
c. CAD  
Due to (or as a consequence of):  
d. CMA

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Nakum MD

29c. License number

047094

29d. Date signed (Month, Day, Year)

3/26/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. NATESAN 106 MILFORD STREET SUITE 504 S SALISBURY, MD 21804

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

Sparks

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item: 26 per M.D G-770 re State of Maryland / Department of Health and Mental Hygiene  
 Items: 10a, b, c, c, e, f per Informant G-770 **Certificate of Death**

Reg. No.

99 12128

|  |   |  |   |  |  |   |   |  |  |  |  |  |
|--|---|--|---|--|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William Lee Martin</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1999</b>  |   |   |  | 3. Time of Death<br><b>4:30 p.m.</b>   |  |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>12113 Mount Pleasant Drive</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>  |   |   |  | 4c. County of Death<br><b>Prince George's</b>  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>210-05-6987</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b>  |   | 8. Date of Birth (Month, Day, Year)<br><b>July 8, 1919</b>              |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                |  |  |  |
|  | Usual Residence of Decedent   |  | 10a. State<br><b>VIRGINIA</b>   |  | 10b. County<br><b>ARLINGTON</b>  |   | 10c. City, Town, or Location<br><b>ARLINGTON</b>                        |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>12113 Mount Pleasant Drive</b>   |  | 10f. Zip Code<br><b>20708</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |  |  |  |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII &amp; Korean</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4+</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Contracts Manager</b>       |  | 16b. Kind of Business/Industry<br><b>Department of Defense</b>   |   |   |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Frederick D. Martin</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Blenko</b>   |   |   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jane Denney Friend</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12113 Mount Pleasant Drive, Laurel, Maryland 20708</b>                                   |   |   |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cem.</b>                                    |  | Date<br><b>4/15/99</b>   |   | 20c. Location - City or Town, State<br><b>Arlington, Virginia</b>       |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>John M. Peters</i>  |  |   |  | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons, Inc.<br/>5130 Wisconsin Avenue, NW, Washington D.C. 20016</b>   |   |   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pancreatic Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |   |   |  |  |  | Approximate Interval Between Onset and Death |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |  |
|  |   |  |   |  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA |   | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>FRIEND'S HOUSE</b> |  |   |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                           |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>John Feigert</i>   |   |  |  | 29c. License number<br><b>046366</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>John Feigert, M.D. 1715 George Mason Drive, Arlington VA 22205</b>  |   |  |   |  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |   | 32. Registrar's Signature<br><i>Bevera B. Sparks</i>   |   |  |  |   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12129

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |  |  |  |   |   |  |
|--|--|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Frank Nickilos Mazzilli</b>   |  | 2. Date of Death<br>Month Day Year<br><b>March 27, 1999</b>  |  | 3. Time of Death<br><b>7:10 AM</b>   |   |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>15708 Atlantis Drive</b>  |  |  | 4b. City, Town, or Location of Death<br><b>Bowie</b> |  | 4c. County of Death<br><b>Prince George's</b> |   |  |
| 5. Social Security Number<br><b>140-18-4008</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>June 06, 1923</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Jersey City, NJ</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>  |   | 10c. City, Town or Location<br><b>Bowie</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>15708 Atlantis Drive</b>  |  | 10f. Zip Code<br><b>20716</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates <b>1943-1946</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Security Guard</b>   |  | 16b. Kind of Business/Industry<br><b>Board of Education</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Mauro Mazzilli</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Mary Negrello</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda Mazzilli Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15708 Atlantis Drive, Bowie, MD 20716</b>  |   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b> |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Cross Chapel Mausoleum</b>   |  | 20c. Location - City or Town, State<br><b>March 30, 1999 North Arlington, New Jersey</b>   |  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Parow Funeral Home<br/>185 Ridge Rd., North Arlington, NJ 07031</b>  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. METASTATIC CANCER (UNKNOWN PRIMARY)</b><br>Due to (or as a consequence of):<br><b>c. </b><br>Due to (or as a consequence of):<br><b>d. </b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)<br><b>March 27, 1999</b>   |  |
| 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>041698</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>03/27/99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>STEPHEN C. HAMILTON, MD 205 RIDGELY AVE. ANNAPOLIS, MD</b>  |  | 31. Data filed (Month, Day, Year)<br><b>MAR 31 1999</b>  |  | 32. Registrar's Signature<br>  |   |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





MCut

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12130

|  |   |  |   |  |  |  |   |  |  |  |
|--|---|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Luster Clark McCutcheon, Jr.  |  |   |  |  | 2. Date of Death<br>Month Day Year<br>March 29, 1999                     |   | 3. Time of Death<br>4:17 PM  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Wilson Health Care Center   |  |   |  |  | 4b. City, Town, or Location of Death<br>Gaithersburg                     |   | 4c. County of Death<br>Montgomery  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>236-14-3857  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>84 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>May 10, 1914   |  | 9. Birthplace (State or Foreign Country)<br>West Virginia  |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Gaithersburg  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>211 Russell Avenue  |  |   |  | 10f. Zip Code<br>20877   |  | 10g. Citizen of What Country?<br>United States  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1943/1945   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher |  |  | 16b. Kind of Business/Industry<br>Education   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Luster Clark McCutcheon  |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Iva Constance Shomo |   |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br>Elizabeth O. McCutcheon/Wife  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>211 Russell Avenue, # 721, Gaithersburg, MD. 20877  |  |   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory  |  | Data<br>3/30/99  |  | 20c. Location - City or Town, State<br>Alexandria, Virginia                                 |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>DeVol Funeral Home<br>10 East Deer Park Dr., Gaithersburg, MD. 20877   |  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Coronary Artery Disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br>Years  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension<br>Hypothyroidism  |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>020516  |  | 29d. Date signed (Month, Day, Year)<br>March 30, 1999                                       |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joel Schulman, 9410 Old Georgetown, Bethesda, Md. 20814   |  |   |  |  |  |   |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br>APR 01 1999  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ALEXANDER MCKINNEY, Jr.</b>   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 24, 1999</b>   |   | 3. Time of Death<br><b>1600</b>  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Montgomery General Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Olney</b>  |   | 4c. County of Death<br><b>MONTGOMERY</b>   |
| 5. Social Security Number<br><b>410-20-8069</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 3, 1925</b> | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b>   |
| Usual Residence of Decedent  |  |   |   |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Rockville</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>14635 Bauer Drive, #307</b>   |  | 10f. Zip Code<br><b>20853</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-45</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>4 yrs</b>   |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Systems Analyst</b>  |  | 16b. Kind of Business/Industry<br><b>Government</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alexander McKinney, Sr.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Janie Davis</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria McKinney (Wife)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14635 Bauer Dr., #307, Rockville, MD 20853</b>  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>J.O. Patterson F/Home</b>  |   | 20c. Location - City or Town, State<br><b>3/27/99 Memphis, TN</b>  |
| 21. Signature of Funeral Service Licensee<br><i>George R. Snowden</i>  |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>   |   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>CARDIAC Arrest</b><br>Due to (or as a consequence of):<br><br>b. <b>CARDIAC Arrhythmia</b><br>Due to (or as a consequence of):<br><br>c. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   | Approximate Interval Between Onset and Death<br><br><b>minutes</b><br><br><b>minutes</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Anoxic Brain injury</b><br><b>Lung Cancer</b><br><b>Diabetes Mellitus</b>   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)<br><b>M</b>  |   | 28b. Time of injury<br><b>1</b> Yes <input type="checkbox"/> No  |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Joseph A Ball MD</b>   |  | 29c. License number<br><b>D 53317</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 24 1999</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>16220 Frederick Road Suite 213 Gaithersburg MD 20877</b>  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>  |  | 32. Registrar's Signature<br><i>B. Spahr</i>  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12132

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Sylvester Leland McManus

2. Date of Death  
Month Day Year  
March 26, 19993. Time of Death  
9:40AM

4a. Facility Name (If not institution, give street and number)

Mariner Health Care-Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

362-10-1565

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 21, 1907

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7056 Wolf tree Lane

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Superintendent

16b. Kind of Business/Industry

Chemicals

17. Father's Name (First, Middle, Last)

Edward F. McManus

18. Mother's Name (First, Middle, Maiden Summa)

Anne Schuster

19a. Informant's Name/Relationship (Type, Print)

Michael D. McManus/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7056 Wolf tree Lane, Rockville, Maryland 20852

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)March 27, 1999  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

David E. Perry M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave.  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

5 Minutes

b. Arrhythmia

Due to (or as a consequence of):

Years

c. Congestive Heart Failure

Due to (or as a consequence of):

Years

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
cause (disease or injury  
that initiated events  
resulting in death) last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multi-infarct Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H.D.

29c. License number

D19609

29d. Date signed (Month, Day, Year)

March 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman R. Tuli, M.D. 10810 Darnestown Road, #202, Gaithersburg, MD 20878

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

Raman R. Tuli

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

09 12133

Amend #10e, 17, 18, 19a 4/8/99, BMW, Montg. Co

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SUSAN MEYERS

2. Date of Death

04.01.1999

Year

3. Time of Death

1AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

063.07.6163

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09.30.1911

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number 6111 Montrose Road

~~6817 TILDEN LANE~~

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LEGAL SECRETARY

16b. Kind of Business/Industry

INSURANCE

17. Father's Name (First, Middle, Last)

LOUIS ~~NATZER~~ Netzer

18. Mother's Name (First, Middle, Maiden Surname)

~~HELEN~~ HERZOG  
Helen

19a. Informant's Name/Relationship (Type, Print)

~~LOREN JAMISON~~/GRANDDAUGHTER  
Lauren Jamieson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6817 TILDEN LANE, ROCKVILLE, MARYLAND 20852

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. COMFORT CREMATORY

Date

4.5.99

20c. Location - City or Town, State

ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL THROMBOSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GENERALIZED ATHEROSCLEROSIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus, Type 2

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18084

29d. Date signed (Month, Day, Year)

APRIL 01, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.D. PATEL, M.D. 6121 Montrose Rd, Rockville MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at least once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12134

|   |  |                           |   |  |  |   |  |  |  |  |
|---|--|---------------------------|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Edward Albert Michaels                         |                           |   |  |  |   | 2. Date of Death<br>Month Day Year<br>March 26, 1999                                 |  | 3. Time of Death<br>10:00am                              |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>8804 Mourning Dove Court |                           |   |  |  |   | 4b. City, Town, or Location of Death<br>Gaithersburg                                 |  | 4c. County of Death<br>Montgomery                        |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-62-6723   |                           | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>43 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Dec. 5, 1955                                  |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |  |
|   | Usual Residence of Decedent  |                           |   |  |  |   |  |  |  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Montgomery |   | 10c. City, Town or Location<br>Gaithersburg  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>8804 Mourning Dove Court  |  |                           |   |  |  | 10f. Zip Code<br>20879  |  | 10g. Citizen of What Country?<br>United States   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4   |  |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales Manager |  |   | 16b. Kind of Business/Industry<br>Home Improvement                                   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Edward Theodore Michaels   |  |                           |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emma Bertha Staudte  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Gail Anne Michaels (Wife)   |  |                           |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8804 Mourning Dove Court, Gaithersburg, MD 20879 |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parklawn Memorial Park  |  | Date<br>Mar. 29, 1999  |   | 20c. Location - City or Town, State<br>Rockville, Maryland                           |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Curtis E. Day  |  |                           |   |  |  | 22. Name and Address of Facility<br>DeVol Funeral Home<br>10 East Deer Park Drive<br>Gaithersburg, MD 20877                                       |  |  |  |  |
| 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Insulin dependant Diabetes YRS.<br>Due to (or as a consequence of):<br>b. Peripheral vascular disease YRS.<br>Due to (or as a consequence of):<br>c. Anemia YRS.<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                           |   |  |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                           |   |  |  |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |                           |   |  |  |   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                           |   |  |  |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                           |   |  |  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |                           | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                        |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                           |   |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>Swaroop Rao  |  |                           |   |  |  | 29c. License number<br>D 35792  |  | 29d. Date signed (Month, Day, Year)<br>March 26, 1999  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Swaroop Rao, MD 50 W. Edmonston Drive, Rockville, MD 20850  |  |                           |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 30 1999  |  |                           |   |  |  | 32. Registrar's Signature<br>Geneva B. Sparks   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12135

|  |  |  |   |  |  |  |  |  |  |  |   |  |
|--|--|--|---|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>BELLE MICHELSON  |  |   |  | 2. Date of Death<br>Month Day Year<br>MARCH 31, 1999   |  |  |  | 3. Time of Death<br>7:02 PM  |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>MANOR CARE - POTOMAC   |  |   |  | 4b. City, Town, or Location of Death<br>POTOMAC  |  |  |  | 4c. County of Death<br>MONTGOMERY  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>578-07-2224   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>84 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>JULY 4, 1914                                  |  | 9. Birthplace (State or Foreign Country)<br>VIRGINIA   |  |   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |  |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND   |  | 10b. County<br>MONTGOMERY   |  | 10c. City, Town or Location<br>POTOMAC   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
|  | 10e. Street and Number<br>8601 SNOWHILL COURT  |  |   |  | 10f. Zip Code<br>20854   |  | 10g. Citizen of What Country?<br>UNITED STATES                                       |  |  |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |  |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOUSEWIFE                                |  |  | 16b. Kind of Business/Industry<br>OWN HOME |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner                                | 17. Father's Name (First, Middle, Last)<br>DAVID SILVER  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>EVA WILKINS   |  |  |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>MICHELE DAVIDSON (DAUGHTER)  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8601 SNOWHILL COURT - POTOMAC, MARYLAND 20854   |  |  |  |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>B'NAI ISRAEL CONG. CEM.  |  | 20c. Location - City or Town, State<br>OXON HILL, MARYLAND                           |  | 20d. Date<br>4-4-99  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Donald C. Stottmeyer</i>   |  |   |  | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852   |  |  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. MYOCARDIAL INFARCTION<br>Due to (or as a consequence of):<br><br>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br>MINUTES<br>YEARS  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CVA<br>POLYOMOSITIS<br>DEMENTIA  |  |   |  |  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |   |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |  |  | 29b. Signature and title of certifier<br><i>Michael J. Grady</i>  |  |
|  | 29c. License number<br>D0038781  |  |   |  |  |  |  |  |  |  | 29d. Date signed (Month, Day, Year)<br>APRIL 1, 1999  |  |
| State<br>Registrar   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MICHAEL GRADY, MD - 4910 MASSACHUSETTS AVE., NW #312 - WASHINGTON, DC 20016-4300   |  |   |  |  |  |  |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br>APR 02 1999   |  | 32. Registrar's Signature<br><i>Barbara B. Sparks</i>   |  |  |  |  |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 12136

|  |  |  |   |   |  |                          |  |  |   |  |   |  |
|--|--|--|---|---|--|--------------------------|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>MYRA ELAINE MILLER   |  |   |   | 2. Date of Death<br>Month Day Year<br>March 27 1999  |                          |  |  | 3. Time of Death<br>11:00 pm  |  |   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>Mariner Health Care - Arcola   |  |   |   | 4b. City, Town, or Location of Death<br>Silver Spring  |                          |  |  | 4c. County of Death<br>Montgomery   |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>176-10-7039   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>83 Yrs.  |                          | 8. Date of Birth (Month, Day, Year)<br>Aug 6, 1915 |  | 9. Birthplace (State or Foreign Country)<br>PA  |  |   |  |
|  | Usual Residence of Decedent  |  |   |   | 10a. State<br>MD   |                          |  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Kensington   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 10e. Street and Number<br>4024 Simms Drive   |                          |  |  | 10f. Zip Code<br>20895  |  | 10g. Citizen of What Country?<br>USA  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |                          |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Registered Nurse  |                          |  |  | 16b. Kind of Business/Industry<br>United States Army  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>John H. Miller  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Myrtle Gates  |                          |  |  |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Donna L. Corbin / Niece  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4024 Simms Drive, Kensington, MD 20895  |                          |  |  |   |  |   |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory   |                          |  |  | 20c. Location - City or Town, State<br>Alexandria, VA   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Anchev J. Cole</i>   |  |   |   | 22. Name and Address of Facility<br>Collins Funeral Home<br>500 University Blvd West, Silver Spring, MD 20901  |                          |  |  |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cerebrovascular accident</i><br>Due to (or as a consequence of): |  |   |   |  |                          |  |  | Approximate Interval Between Onset and Death<br>72h   |  |   |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.   |  |   |   |  |                          |  |  |   |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>aspiration pneumonia</i>  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                          |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred              |   |  |
|  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   | 29b. Signature and title of certifier<br><i>Myron L. Lenkin</i>   |  |                          |  | 29c. License number<br>00667X  |   | 29d. Date signed (Month, Day, Year)<br>3/29/99 |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MYRON L. LENKIN MD<br>2309 SHOREFIELD RD<br>WHITEHATON MD 20902  |  |  |   |   |  |                          |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 30 1999   |  |  |   | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |                          |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12137

|   |   |   |  |  |   |   |   |  |
|---|---|---|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Anne Mustafa</b>   |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1999</b> |   | 3. Time of Death<br><b>6:35A.</b>                           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>              |   | 4c. County of Death<br><b>Montgomery</b>                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-44-4315</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>June 23, 1944</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>                                     |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>                                      |   | 10c. City, Town or Location<br><b>Dickerson</b>             |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>19710 Martinsburg Road</b>   |  | 10f. Zip Code<br><b>20842</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chemist</b>                       |  | 16b. Kind of Business/Industry<br><b>United States Govn't</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Alfred Johnson</b>  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mildred Evelyn Carlton</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Faris Mustafa (husband)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 244 Poolesville, Maryland 20837</b>   |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>George Washington Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Donald V. Borgwardt</b>  |   | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hepatorenal Failure</b><br>Due to (or as a consequence of):<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><b>Anastamotic leak</b><br>Due to (or as a consequence of):<br><b>Gastric bypass</b> |   | Approximate Interval Between Onset and Death<br><b>3 days</b><br><b>13 days</b><br><b>13 days</b><br><b>14 days</b>                               |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   |  |
| 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how Injury occurred   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>W F Marcus MD</b>   |   |  |
| 29c. License number<br><b>007040</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/26/99</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>William Marcus, M.D. 10801 Lockwood Drive Silver Spring, Maryland 20901</b>   |   | 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |   |  |
| 32. Registrar's Signature<br><b>Geneva B. Sparks</b>  |   |   |  |  |   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MAJORIE MAGRUDER</b>  |  |   |  | 2. Date of Death<br>Month <b>03</b> Day <b>29</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>11:30pm</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>HCR/Manor Care Health Services</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Wheaton, MD</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>578-30-2657A</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 17, 1925</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |  | 10a. State<br><b>District of Columbia</b>   |  | 10b. County<br><b>Washington, DC</b>  |  | 10c. City, Town or Location<br><b>Washington, DC</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>3044 M St., SE</b>   |  | 10f. Zip Code<br><b>20019</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12th</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House wife</b>  |  | 16b. Kind of Business/Industry<br><b>Private</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Linwood Hamilton</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jennie B. Smith Hamilton</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas Magruder/husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3044 M St., SE Washington, DC 20019</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Bladensburg, MD</b>   |  | 20d. Date<br><b>4-3-99</b>  |  | 21. Signature of Funeral Service licensee<br>  |  |
| 22. Name and Address of Facility<br><b>Latney's Funeral Home, Inc. 3831 Georgia Ave., NW Wash., DC 20011</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Respiratory insufficiency</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |
| 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Uma Prasad M.D.</b>  |  |
| 29c. License number<br><b>MD 17310</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 1, 1999</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Uma Prasad, M. D. 2100 Pennsylvania Ave., NW Wash., DC 20037</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 02 1999</b>  |  |
| 32. Registrar's Signature<br>  |  |   |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12139

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harriett Boswell Maloy

2. Date of Death

Mar 26 1999

3. Time of Death

2:10 am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-14-6884

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 13, 1908

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2700 Barker Street

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Years:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Investigator

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Jesse C. Boswell

18. Mother's Name (First, Middle, Maiden Surname)

Marianna Russell

19a. Informant's Name/Relationship (Type, Print)

Carla D. Fogle/ Grandchild

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1660 Pinetree Drive, Upper St. Clair, PA 15241

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

3/27/99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc., 500 University Blvd, West, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease many years

Due to (or as a consequence of):

c. Cerebral Vascular Accident

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

6 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Tanya C. Lumpkins MD*

29c. License number

MD- D44321

29d. Date signed (Month, Day, Year)

Mar 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tanya C. Lumpkins 9500 Annapolis Road, #A-1, Lanham, MD 20706

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

*B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12140

|  |  |   |  |  |   |  |  |  |
|--|--|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARIAN LOWE MANN</b>                                  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 24, 1999</b> |  | 3. Time of Death<br><b>2:30 A.M.</b>                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MONTGOMERY GENERAL HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>OLNEY</b>        |  | 4c. County of Death<br><b>MONTGOMERY</b>                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-28-7600</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug 28, 1916</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>                            |  | 10c. City, Town or Location<br><b>Gaithersburg</b>         |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>101 Odendhal Avenue, #506</b>  |  | 10f. Zip Code<br><b>20877</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>School Board</b>  |  | 16b. Kind of Business/Industry<br><b>Montgomery County</b>   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lawrence N. Lowe</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Holmes</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Norma M. Christofano, daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>503 Woodland Road, Gaithersburg, MD 20877</b>  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Darnestown Presbyterian Church Cemetery</b>  |  | Data<br><b>Mar 27, 1999</b>  |   | 20c. Location - City or Town, State<br><b>Darnestown, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home<br/>10 East Deer Park Dr., Gaithersburg, MD 20877</b>  |   |  |  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Breast Cancer with metastatic Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Pericardial effusion</b><br>Due to (or as a consequence of):<br><b>c. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HTSP</b><br><b>Pericardial effusion</b><br><b>Coronary Artery Disease</b>   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D18726</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 24, 1999</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Barbara Schengold MD 18101 Prince Philip Dr, Olney MD 20832</b>   |  |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12141

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anthony W. Marlowe

2. Date of Death

Month Day Year  
MARCH 26, 1999

3. Time of Death

1819 PM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

129-22-1162

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 29, 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15012 Red Clover Drive

10f. Zip Code

20853

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Golf Professional

16b. Kind of Business/Industry

Golf

17. Father's Name (First, Middle, Last)

John Miraglio

18. Mother's Name (First, Middle, Maiden Summa)

Ethel Pittman

19a. Informant's Name/Relationship (Type, Print)

Tina M. Uihlein / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 Hastings Court, Dartmouth, Massachusetts 02747

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc. April 1, 1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Barbara J. McMillen Lawrence

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Hypertensive Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

XX Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient

XX ER/Outpatient

3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

MARCH 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore M. King

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12142

|   |  |  |  |  |   |  |  |  |
|---|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Henry Augustine Mullen   |  |  |  | 2. Date of Death<br>Month Day Year<br>March 30 1999   |  | 3. Time of Death<br>4:45 PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>St. Mary's Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Leonardtown   |  | 4c. County of Death<br>St. Mary's  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>106-26-1686   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>63 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>July 21, 1935   |  |
|   | 9. Birthplace (State or Foreign Country)<br>New York   |  | 10a. State<br>Maryland   |  | 10b. County<br>St. Mary's   |  | 10c. City, Town or Location<br>California  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br>45562 Baringer Drive  |  | 10f. Zip Code<br>20619   |  |
|   | 10g. Citizen of What Country?<br>United States   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1955-1980  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Noncommissioned Officer   |  |  |  | 16b. Kind of Business/Industry<br>Defense   |  | 17. Father's Name (First, Middle, Last)<br>Augustine Bernard Mullen  |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Murray   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Beatrice Desimone   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 683, California, Maryland 20619  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Immaculate Heart of Mary  |  | 20c. Location - City or Town, State<br>Lexington Park, MD  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Edward N. Brinsfield, Jr. M00052  |  |  |  | 22. Name and Address of Facility<br>Brinsfield Funeral Home, P.A.<br>22955 Hollywood Road, Leonardtown, MD 20650  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cancer / Metastasis</i><br>b. <i>Pneumonia</i><br>c. <i>Mitral Regurgitation</i><br>d. <i>Septis</i> |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |
|   | 28a. Date of injury (Month, Day Year)<br>28b. Time of injury<br>M<br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br>Thurman, MD  |  | 29c. License number<br>D34539  |  |
|   | 29d. Date signed (Month, Day, Year)<br>3.31.99   |  |  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>KHALID M. HUSAIN M.D. 22576 MacArthur Blvd. Suite 354 California, Md. 20619   |  | 31. Date filed (Month, Day, Year)<br>APR 1 1999  |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br>B. Sparks   |  |  |  | 33. State Registrar<br>APR 1 1999   |  | 34. State Registrar<br>APR 1 1999  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

HENRY AUGUSTINE MULLEN

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



99 12143

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Harold Jasper Miller</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 30, 1999</b>  |  | 3. TIME OF DEATH<br>M<br><b>13:40</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>211-18-1059</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>December 22, 1927</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Hyman, PA</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Kent &amp; Queen Annes Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chestertown</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Kent</b>   |  |   |  | 10a. STATE<br><b>Maryland</b>  |  |  |  |
| 10b. COUNTY<br><b>Queen Annes</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Sudlersville</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1102 Dell Foxx Road</b>   |  |
| 10f. ZIP CODE<br><b>21668</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>U.S. Army</b> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mechanic</b>  |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br><b>Automobile Dealership</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Harold Marion Miller</b>  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Helen Grace Barkley</b>  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Jeanette K. Miller/Wife</b>   |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1102 Dell Foxx Road, Sudlersville, Maryland 21668</b>  |  | 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>April 1, 1999</b><br><b>Chesapeake Cremation Center, LLC</b>   |  | 20c. LOCATION — City or Town, State<br><b>Stevensville, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.O. Box 270, Millington, Maryland 21651-0270</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>CARDIOGENIC SHOCK</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>CORONARY ARTERY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>2 hrs</b><br><b>18 hrs</b><br><b>&gt; 3 yrs.</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br><b>DIABETES MELLITUS</b>   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO               |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M<br><b>1</b> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Helen Noble MD</b>   |  | 29c. LICENSE NUMBER<br><b>D41587</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/99</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Helen Noble, MD, 120 Speer Road, Chestertown, MD 21620</b>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>APR 02 1999</b>  |  |
| 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



WRC  
99-1888-510  
THOMAS  
MAYBIN JR. ITEMS: #23 PART I, 27 PER MEO G770 4-17-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12144

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |                                |  |  |  |  |  |
|---|--|---|--|--|--------------------------------|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>THOMAS ANDREW MAYBIN, JR.   |  |   |  | 2. Date of Death<br>Month Day Year<br>MARCH 31, 1999   |                                |  |  | 3. Time of Death<br>8:18 PM.                               |  |  |
| 4a. Facility Name (If not Institution, give street and number)<br>GOOD SAMARITAN HOSPITAL   |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |                                |  |  | 4c. County of Death<br>NONE                                |  |  |
| 5. Social Security Number<br>212-19-2867  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>21 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>JAN. 8, 1978                                  |  | 9. Birthplace (State or Foreign Country)<br>WASHINGTON, DC |  |  |
| Usual Residence of Decedent   |  |   |  | 10a. State<br>MARYLAND   |                                |  |  | 10b. County<br>PRINCE GEORGES                              | 10c. City, Town or Location<br>FORT WASHINGTON | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br>9705 POLING TERRACE   |  |   |  | 10f. Zip Code<br>20744   |                                | 10g. Citizen of What Country?<br>UNITED STATES                                       |  |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2 YEARS   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>STUDENT |  |                                | 16b. Kind of Business/Industry<br>EDUCATION  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>THOMAS ANDREW MAYBIN, SR.  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>REGINA MARIE SHAW   |                                |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>REGINA M. SHAW / MOTHER   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1414 SOUTHVIEW DR. #304, OXON HILL, MARYLAND 20745  |                                |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>HARMONY MEMORIAL PARK   |  | Date<br>4/6/99   |                                | 20c. Location - City or Town, State<br>HYATTSVILLE, MARYLAND                         |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Ledia C. Thornton Johnson</i><br>LEDIA C. THORNTON JOHNSON M00583   |  |   |  | 22. Name and Address of Facility<br>THORNTON FUNERAL HOME, P.A.<br>3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640   |                                |  |  |  |  |  |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. ARRHYTHMOGENIC RIGHT VENTRICULAR DYSPLASIA<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |  |                                |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                          |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>J. Pustan, M.D.</i>   |  | 29c. License number<br>O.C.M.E.  |                                | 29d. Date signed (Month, Day, Year)<br>APRIL 01, 1999                                |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201  |  |   |  |  |                                |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 02 1999  |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |                                |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |   |                                |  |   |
|---|--|---|--|---|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>VIRGINIA HAZEL MECHEM</b>  |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>17</b> Year <b>1999</b>   |                                | 3. Time of Death<br><b>3:00 P.M.</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>ALLEGANY COUNTY NURSING HOME</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>   |                                | 4c. County of Death<br><b>ALLEGANY</b>   |   |
| 5. Social Security Number<br><b>233-50-9473</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 28, 1913</b>  |   |
| 9. Birthplace (State or Foreign Country)<br><b>WEST VIRGINIA</b>  |  |   |  |   |                                |  |   |
| Usual Residence of Decedent   |  |   |  |   |                                |  |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>ALLEGANY</b>  |  | 10c. City, Town or Location<br><b>CUMBERLAND</b>  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>923 BEDFORD STREET</b>   |  |   |  | 10f. Zip Code<br><b>21502</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |                                | 16b. Kind of Business/Industry<br><b>HOME</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>IRVIN HENRY</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>AMANDA PAYNE</b>  |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ARLENE FOREBACK / DAU.</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1424 DOGWOOD COURT, CUMBERLAND, MD 21502</b>  |                                |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HILLCREST BURIAL PARK</b>  |  | Date<br><b>3/20/99</b>  |                                | 20c. Location - City or Town, State<br><b>CUMBERLAND, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><i>Standy N. Upchurch</i>  |  |   |  | 22. Name and Address of Facility<br><b>UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>   |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Ca of Cecum</i><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |                                |  | Approximate Interval Between Onset and Death<br><b>ONE YEAR</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
|   |  |   |  |   |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |
|   |  |   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred   |                                |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |                                |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |                                |  |   |
| 29b. Signature and title of certifier<br><i>Robustiano J. Barrera</i>   |  |   |  | 29c. License number<br><b>D-14865</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>MARCH 20, 1999</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBUSTIANO J. BARRERA, M.D.-500 MEMORIAL AVENUE, CUMBERLAND, MD 21502</b>  |  |   |  |   |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 25 1999</b>   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |                                |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

ms

State  
Registrar





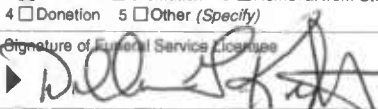

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12146

|  |  |   |  |  |  |   |  |                                   |  |  |  |
|--|--|---|--|--|--|---|--|-----------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Agnes S. Means</b>                                |   |  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>March 23, 1999</b>                                    |                                   | 3. Time of Death<br><b>3:30 AM</b>                               |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Cumberland Nursing Home</b> |   |  |  |  |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>                                      |                                   | 4c. County of Death<br><b>Allegany</b>                           |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-07-6014</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>Jun. 22, 1911</b>                                    |                                   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b> |  |  |
|  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Allegany</b>   |  | 10c. City, Town or Location<br><b>Cumberland</b> |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |  |  |
| 10e. Street and Number<br><b>213 Knox St.</b>  |  | 10f. Zip Code<br><b>21502</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |                                   |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |                                   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business/Industry<br><b>Factory</b>   |  |   |  |                                   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thronton Means, Sr.</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth (Smith)</b>   |  |                                   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty J. Means</b>  |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>714 Lincoln St., Cumberland, MD 21502</b> |  |                                   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hillcrest Memorial Park</b>  |  | Date<br><b>3/25/99</b>   |  | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>  |  |                                   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Kight Funeral Home<br/>309-311 Decatur St., Cumberland, MD 21502</b>   |  |  |  |   |  |                                   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Coronary artery Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  |                                   |  | Approximate Interval Between Onset and Death<br><b>5 yrs</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>  |  |   |  |  |  |   |  |                                   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |                                   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |                                   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>033280</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 24, 1999</b>  |  |                                   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sunil K. Gupta, M. D., 625 Kent Ave., # 101, Cumberland, MD 21502</b>   |  |   |  |  |  |   |  |                                   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 25 1999</b>  |  | 32. Registrar's Signature<br>  |  |  |  |   |  |                                   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12147

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |  |                                |  |   |
|---|--|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>ANNA ELIZABETH MYERS</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 20 1999</b>   |                                | 3. Time of Death<br><b>9:27 AM</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |                                | 4c. County of Death<br><b>ALLEGANY</b>   |   |
| 5. Social Security Number<br><b>212 01 9660</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 24, 1907</b>   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
| Usual Residence of Decedent   |  |   |  |  |                                |  |   |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ALLEGANY</b>  |  | 10c. City, Town or Location<br><b>FROSTBURG</b>  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>80 WASHINGTON STREET</b>   |  |   |  | 10f. Zip Code<br><b>21532</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.</b>   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b>   |  | College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SEAMSTRESS</b>   |                                | 16b. Kind of Business/Industry<br><b>SHIRT FACTORY</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>PHILIP EVERLINE</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNA KROLL</b>   |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JOANNE CLISE / NIECE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>201 DELANO AVE., FROSTBURG, MD 21532</b>   |                                |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FROSTBURG MEMORIAL PARK</b>  |  | Date<br><b>3/22/99</b>   |                                | 20c. Location - City or Town, State<br><b>FROSTBURG, MD 21532</b>  |   |
| 21. Signature of Funeral Service Licensee<br><i>Eric Sowers</i>   |  |   |  | 22. Name and Address of Facility<br><b>SOWERS FUNERAL HOME, P.A.<br/>60 W. MAIN ST., FROSTBURG, MD 21532</b>   |                                |  |   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Due to (or as a consequence of):<br><b>ACUTE MYOCARDIAL INFARCTION</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of): |  |   |  |  |                                | Approximate Interval Between Onset and Death<br><b>4 days</b>  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b>   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>S. Chang M.D.</i>   |  | 29c. License number<br><b>D 25638</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>MARCH 23 1999</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SATURNINA T. CHANG M.D. RT 36 FROSTBURG PLAZA FROSTBURG MD 21532</b>   |  |   |  |  |                                |  |   |
| 31. Date of Death (Month, Day, Year)<br><b>MAR 23 1999</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |                                |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12148

|  |   |  |   |   |  |  |   |   |  |   |  |
|--|---|--|---|---|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>HAROLD VERNON MORGAN  |  |   |   | 2. Date of Death<br>Month Day Year<br>MARCH 30 1999  |  |   |   | 3. Time of Death<br>8:55 a.m.  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>MEMORIAL HOSPITAL MEDICAL CENTER  |  |   |   | 4b. City, Town, or Location of Death<br>CUMBERLAND   |  |   |   | 4c. County of Death<br>ALLEGANY  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-24-7209  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>69 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>FEB 21 1930    |   | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |   |  |
|  | Usual Residence of Decedent   |  |   |   |  |  |   |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND  |  | 10b. County<br>ALLEGANY   |   | 10c. City, Town or Location<br>CUMBERLAND  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
|  | 10e. Street and Number<br>627 PRINCETON STREET  |  |   |   | 10f. Zip Code<br>21502   |  | 10g. Citizen of What Country?<br>U.S.A.               |   |  |   |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+) 8   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>ELECTRICIANS HELPER   |  |   |   | 16b. Kind of Business/Industry<br>ELECTRICIAN  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>MERTEN ISSAC MORGAN  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>JULIA PLEASANT HYMES  |  |   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>WILLIAM F. MORGAN BROTHER   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>RFD# 2 BOX#246 RIDGELEY, W.VA. 26753  |  |   |   |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>PROSPERITY METH. CEMETERY   |   | 20c. Date<br>APRIL 1 1999  |  | 20d. Location (City or Town, State)<br>Flintstone MD. |   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Dale L. Merritt</i>   |  |   |   | 22. Name and Address of Facility<br>MERRITT-ADAMS FUNERAL HOME<br>404 DECATUR STREET CUMBERLAND MARYLAND   |  |   |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. RESPIRATORY FAILURE<br>Due to (or as a consequence of):<br>C.O.P.D.<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |   |   |  |  |   |   | Approximate Interval Between Onset and Death<br>ONE YEAR<br>TEN YEARS  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  |   | 29c. License number<br>D 12779  |  | 29d. Date signed (Month, Day, Year)<br>3/31/99  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>500 MEMORIAL AVENUE, CUMBERLAND, MARYLAND 21502  |   |  |   |   |  |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999   |   |  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |   |  |   |  |

MERRITT-ADAMS FUNERAL HOME

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HAROLD MORGAN (213-24-7209)

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12149  
Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>ALICE FAYE MORGAN   |  |   |  | 2. Date of Death<br>Month Day Year<br>MARCH 24, 1999   |  | 3. Time of Death<br>12:10 PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>32520 MT. OLIVE RD.   |  |   |  | 4b. City, Town, or Location of Death<br>SALISBURY  |  | 4c. County of Death<br>WICOMICO  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>213-42-0849  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>55 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>DEC. 20, 1943                                 |  |
|   | 9. Birthplace (State or Foreign Country)<br>MARYLAND  |  | 10a. State<br>MARYLAND  |  | 10b. County<br>WICOMICO  |  | 10c. City, Town or Location<br>SALISBURY   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>32520 MT. OLIVE RD.   |  | 10f. Zip Code<br>21804   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>PRODUCTION WORKER  |  | 16b. Kind of Business/Industry<br>INDUSTRIAL SUPPLY CO.,   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>EARL MERRITT   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>FRANCES BURKE  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>ROBIN LYNN MORGAN - DAUGHTER  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>32520 MT. OLIVE RD. SALISBURY, MD 21804  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SPRINGHILL MEMORY GARDENS 3-29-99   |  | 20c. Location - City or Town, State<br>HEBRON, MARYLAND  |  | 21. Signature of Funeral Service Licensee<br>B. Keet                                 |  |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility<br>BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Metastatic Malignant Melanoma<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br>6 years  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>James E. Martin, M.D.  |  | 29c. License number<br>D 30690   |  | 29d. Date signed (Month, Day, Year)<br>March 24, 1999                                |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD.   |  | 31. Date filed (Month, Day, Year)<br>MAR 26 1999  |  |  |  |  |  |
|   | 32. Registrar's Signature<br>Benita B. Sparks   |  |   |  |  |  |  |  |

1944 2/25/5



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12150

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert J. Meier Jr.

2. Date of Death

Month

Day

Year

MARCH

18

1999

3. Time of Death

3:05 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

None

Funeral  
Director

5. Social Security Number

219-10-0596

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct 9, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

125 Longview Drive

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1943-4613. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Pet Store

17. Father's Name (First, Middle, Last)

Robert J. Meier Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Theresa M. Tribbe

19a. Informant's Name/Relationship (Type, Print)

Erma A. Meier/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

125 Longview Drive Catonsville, Maryland 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Meadowridge Memorial Park 3-22-99 Elkridge, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Shirley A. Collins-Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Anoxic Brain Injury

Due to (or as a consequence of):

1 hour

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Tension Pneumothorax

Due to (or as a consequence of):

45 minutes

c. Respiratory Distress Syndrome

Due to (or as a consequence of):

11 days

d. Aspiration Pneumonitis

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Michael J. Harris

29c. License number

AT2438946N3

29d. Date signed (Month, Day, Year)

MARCH 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. HARRIS, M.D. 201 EAST UNIVERSITY PARKWAY, BALTIMORE, MD 21218

31. Date filed (Month, Day, Year)

MAR 22 1999

32. Registrar's Signature

Brenda G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.Robert Meier  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12151

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George W. Melvin

2. Date of Death

March 31 1999

3. Time of Death

3:11 PM

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Marys

Funeral  
Director

5. Social Security Number

214-01-2440

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 24 1919

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

Montgomery

10c. City, Town or Location

Brookville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

18911 Abbey Manor Dr.

10f. Zip Code

20833

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Dates

3 Feb 45 - 9 Aug 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Personnel &amp; Sales

16b. Kind of Business/Industry

Exxon Corp.

17. Father's Name (First, Middle, Last)

Louis Melvin

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Shelton

19a. Informant's Name/Relationship (Type, Print)

Gary Melvin/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18911 Abbey Manor Dr. Brookville, Md 20833

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairfax Crematory

Date

4-2-99

20c. Location - City or Town, State

Fairfax, VA

21. Signature of Funeral Service Licenses

David C. Echols MO945

22. Name and Address of Facility

Arehart-Echols Funeral Home, PA  
P.O. Box 567 LaPlata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

one week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Exacerbation of Chronic Obstructive

Due to (or as a consequence of):

c. Pulmonary Disease

not known.

Due to (or as a consequence of):

d. Gastrointestinal Bleeding

not known.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury or Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul S. Jani MD

29c. License number

D45092

29d. Date signed (Month, Day, Year)

4/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul S. Jani MD 110 HOSPITAL ROAD, SUITE #204 FREDRICK PRINCE

State  
Registrar

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

B. Sparks

MD 20678

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12152

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mary Helen Nelson</b>  |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>31</b> Year <b>1999</b>  |  |   |  | 3. Time of Death<br><b>4:15 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>St. Mary's Nursing Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>   |  |   |  | 4c. County of Death<br><b>St. Mary's</b>   |  |
| 5. Social Security Number<br><b>215-18-0356</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>September 25, 1918</b>                            |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
| Usual Residence of Decedent   |  |   |  |  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>Colton's Point</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>P.O. Box 1</b>   |  |   |  | 10f. Zip Code<br><b>20626</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Linen Worker</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Hospital</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Russell</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Rose Pearl Scott</b>                  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Francis B. Nelson, Jr/Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 27, Colton's Point, MD 20626</b>  |  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Charles Memorial Gardens</b>   |  | Date<br><b>4/5/99</b>  |  | 20c. Location - City or Town, State<br><b>Leonardtown, MD</b>                               |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, MD 20650</b>  |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Atherosclerotic Cardiovascular disease</b> <b>yes</b><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____  |  |   |  |  |  |   |  |  |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D14285</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-1-99</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>William D. Boyd II, MD</b> <b>Leonardtown, MD 20650</b>  |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 2 1999</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 12153

|  |   |   |  |  |   |   |  |   |
|--|---|---|--|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Florence Nalley</i>  |   |  |  | 2. Date of Death<br>Month <i>03</i> Day <i>29</i> Year <i>99</i>  |   | 3. Time of Death<br><i>11:50 PM</i>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Mariner Health @ Circle Manor</i>  |   |  |  | 4b. City, Town, or Location of Death<br><i>Kensington</i>   |   | 4c. County of Death<br><i>Montgomery Co.</i>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><i>579-48-6236</i>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><i>94</i> Yrs.   | If Under 1 Year<br>Months <i>0</i> Days <i>0</i>  | If Under 24 Hrs.<br>Hours <i>0</i> Min. <i>0</i>  | 8. Date of Birth (Month, Day, Year)<br><i>11/2/04</i>  | 9. Birthplace (State or Foreign Country)<br><i>Washington, D.C.</i> |
|  | Usual Residence of Decedent   |   |  |  | 10c. City, Town or Location<br><i>Takoma Park</i>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| To Be Completed by Funeral Director  | 10a. State<br><i>Maryland</i>   |   | 10b. County<br><i>Montgomery</i>   |  | 10e. Street and Number<br><i>6613 Eastern Ave.</i>  |   | 10f. Zip Code<br><i>20912</i>  |   |
|  | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Homemaker</i>                     |   | 16b. Kind of Business/Industry<br><i>Own Home</i>  |   |
|  | 17. Father's Name (First, Middle, Last)<br><i>William Franklin Mills</i>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mary Adeline Fister</i>   |   |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Mary Burns - Daughter</i>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3431 Brookville Ln., Woodbridge, VA 22192</i> |   |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Stafford Memorial Park</i>  |  | 20c. Location - City or Town, State<br><i>Stafford, Virginia</i>  |   | 20d. Date<br><i>4/1/99</i>   |   |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |  |  | 22. Name and Address of Facility<br><i>Mountcastle Funeral Home<br/>4143 Dale Blvd., Dale City, VA 22193</i>                                      |   |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Congestive Heart Failure</i><br/>Due to (or as a consequence of):</p> <p>b. <i>Hypertension with Left Ventricular Dysfunction, and chronic obstructive Lung Disease</i><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____<br/>Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>                       |   |  |  |   |   |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>① <i>Renal Insufficiency</i></p> <p>② <i>Electrolytes Imbalance</i></p> <p>③ <i>carcinoma of vulva</i></p> </div> <div style="width: 30%;"> <p>23b. Did tobacco use contribute to the cause of death?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> </div> </div> |   |  |  |   |   |  |   |
|  | Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospice: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
| 28d. Describe how Injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                            |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |   |   |  |   |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.   | 29b. Signature and title of certifier<br><i>Mohammed A. Mannan MD</i>   |   |  |  | 29c. License number<br><i>D24593</i>  |   | 29d. Date signed (Month, Day, Year)<br><i>3.30.99</i>  |   |
|  | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><i>MOHAMMED A. MANNAN, MD, 3331-TOLEDO TERRACE, HYATTSVILLE, MD 20782</i>   |   |  |  |   |   |  |   |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><i>APR 13 1999</i>   |   |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12404  
3. Time of Death  
7:08 PMPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Herbert Levi Naylor

2. Date of Death  
Month Day Year  
APRIL 2, 1999

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

5. Social Security Number

214-26-1490

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 10, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Monkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

539 Gifford Lane

10f. Zip Code

Monkton

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: Korean13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Battalion Chief

16b. Kind of Business/Industry

County Fire Department

17. Father's Name (First, Middle, Last)

Peter Henry Naylor

18. Mother's Name (First, Middle, Maiden Surname)

Edith Merryman

19a. Informant's Name/Relationship (Type, Print)

M. Anne Naylor/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

539 Gifford Lane, Monkton, MD 21111

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Hereford  
Methodist Cemetery

Date

April 6,  
1999

20c. Location - City or Town, State

Hereford, MD

21. Signature of Funeral Service Licensee

J.J. Hartenstein

22. Name and Address of Facility

J.J. Hartenstein Mortuary, Inc.  
24 Second St., New Freedom, PA 1734923a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

RUPTURED THORACIC ANEURYSM

Approximate  
Interval Between  
Onset and Death

10 HOURS

e. Due to (or as a consequence of):  
EXCESSIVE BLOOD LOSS

2 HOURS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter J. Horneffer

29c. License number

D 30446

29d. Date signed (Month, Day, Year)

4/2/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PETER HORNEFFER, M.D., 7505 OSLER DRIVE, TOWSON, MD 21204

31. Date filed (Month, Day, Year)

APR 13 1999

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12155  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>Victor H. Nelson</i>                                     |  |  |  | 2. Date of Death<br>Month <i>March</i> Day <i>30</i> Year <i>99</i> |  | 3. Time of Death<br><i>10 PM</i>                            |  |
| 4a. Facility Name (If not institution, give street and number)<br><i>Prineview Nursing Rehab Center</i> |  |  |  | 4b. City, Town, or Location of Death<br><i>Clinton</i>              |  | 4c. County of Death<br><i>(PG) Prince Georges</i>           |  |
| 5. Social Security Number<br><i>578-58-6246</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><i>54</i> Yrs.                    |  | 8. Date of Birth (Month, Day, Year)<br><i>July 07-10-44</i> |  |
| 9. Birthplace (State or Foreign Country)<br><i>Washington D.C.</i>                                      |  |  |  |   |  |   |  |

Funeral  
Director

|                               |  |                                      |  |   |  |  |  |
|-------------------------------|--|--------------------------------------|--|---|--|--|--|
| 10e. State<br><i>Maryland</i> |  | 10b. County<br><i>Prince Georges</i> |  | 10c. City, Town or Location<br><i>Forestville</i> |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|-------------------------------|--|--------------------------------------|--|---|--|--|--|

|   |  |                               |  |   |  |
|---|--|-------------------------------|--|---|--|
| 10e. Street and Number<br><i>5205 Davenport Terr.</i> |  | 10f. Zip Code<br><i>20747</i> |  | 10g. Citizen of What Country?<br><i>USA</i> |  |
|---|--|-------------------------------|--|---|--|

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i> |  |
|--|--|---|--|--|--|---|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Clerical</i> |  | 16b. Kind of Business/Industry<br><i>Federal Government</i> |  |
|--|--|--|--|---|--|

|   |  |  |  |
|---|--|--|--|
| 17. Father's Name (First, Middle, Last)<br><i>Forest Nelson</i> |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Margaret Butler Nelson</i> |  |
|---|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Wykaine Nelson / Son</i> |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>5205 Davenport Terr. Forestville MD 20747</i> |  |
|---|--|---|--|

|  |  |   |  |                                     |  |
|--|--|---|--|-------------------------------------|--|
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Maryland Veterans Cem. April 8, 1999 Cheltenham MD</i> |  | 20c. Location - City or Town, State |  |
|--|--|---|--|-------------------------------------|--|

|  |  |   |  |
|--|--|---|--|
| 21. Signature of Funeral Service Licensee<br><i>Lloyd H. ESTEP</i> |  | 22. Name and Address of Facility<br><i>Adams 20605 Aguiasco Road Aguiasco, Md 20608</i> |  |
|--|--|---|--|

|   |  |  |  |
|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <i>Right breast Cancer</i><br>Due to (or as a consequence of):<br>b. <i>Metastasis to the lung</i><br>Due to (or as a consequence of):<br>c. <i>Metastasis to the liver</i><br>Due to (or as a consequence of):<br>d. <i>Acute Renal failure</i> |  | Approximate Interval Between Onset and Death |  |
|---|--|--|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Generalized metastasis with bone metastases</i> |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |  |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |

|  |  |
|--|--|
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
|--|--|

|   |  |                     |  |   |  |
|---|--|---------------------|--|---|--|
| 29b. Signature and title of certifier<br><i>Dr. H. Soyars MD Medical Director</i> |  | 29c. License number |  | 29d. Date signed (Month, Day, Year)<br><i>3/30/99</i> |  |
|---|--|---------------------|--|---|--|

|  |  |
|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>4000 Mitchell Rd Bowie Maryland</i> |  |
|--|--|

|   |  |   |  |
|---|--|---|--|
| 31. Date filed (Month, Day, Year)<br><i>3/30/99</i> |  | 32. Registrar's Signature<br><i>James B. Sparks</i> |  |
|---|--|---|--|

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12156

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Joseph Oneil

2. Date of Death

Month Day Year  
Mar 28, 1999

3. Time of Death

3:30pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-22-5669

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11-23-25

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

306 South Waterford Road

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Auditor

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William O'Neil

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Copperthaite

19a. Informant's Name/Relationship (Type, Print)

Linda O. Milbourn / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6607 Wells Parkway, University Park, MD 20782

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

3-31-99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Collins Funeral Home  
500 University Blvd W. Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 weeks

b. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

10+ years

c. Cigarette Smoking

Due to (or as a consequence of):

50+ years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Large bowel perforation

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Ernest Osen MD

29c. License number

D03792

29d. Date signed (Month, Day, Year)

March 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ernest Osen MD

10301 Georgia Ave Silver Spring Md 20902

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit record.

Medical Certification: To Be Completed by Physician/Medical Examiner

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12157**  
Certificate of Death

Reg. No.

|                                     |   |  |   |                                |  |
|-------------------------------------|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BERNARD ORLANS</b>   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>26</b> Year <b>1999</b>   |                                | 3. Time of Death<br><b>7:55 PM</b>   |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>MANOR CARE POTOMAC</b>   |  | 4b. City, Town, or Location of Death<br><b>POTOMAC</b>  |                                | 4c. County of Death<br><b>MONTGOMERY</b>   |
| Funeral<br>Director                 | 5. Social Security Number<br><b>089-07-8900</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>JULY 4, 1912</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b>   |                                |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent   |  |   |                                |  |
|                                     | 10a. State<br><b>MARYLAND</b>   | 10b. County<br><b>MONTGOMERY</b>   | 10c. City, Town or Location<br><b>POTOMAC</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|                                     | 10e. Street and Number<br><b>10714 POTOMAC TENNIS LANE</b>  |  | 10f. Zip Code<br><b>20854</b>   |                                | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:         |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)                               |                                |  |
|                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired.)<br><b>GENERAL MERCHANDISE MANAGER</b>  |  | 16b. Kind of Business/Industry<br><b>MORTON'S DEPARTMENT STORE</b>  |                                |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>ISADORE ORLANS</b>  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>YETTA ROSENBAUM</b>   |                                |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>MELVIN ORLANS (SON)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11304 MORNING GATE DRIVE - N. BETHESDA, MD. 20852</b> |                                |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ADAS ISRAEL CONG. CEM.</b>   |                                | 20c. Location - City or Town, State<br><b>WASHINGTON, D.C.</b>   |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852</b>                    |                                |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><br>b. <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |   |                                | Approximate Interval Between Onset and Death<br><br><b>1 MONTH</b><br><br><b>10 YEARS</b>  |
|                                     | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |                                |  |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                |  |
|                                     | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |                                |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |                                |  |
|                                     | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                | 28d. Describe how injury occurred  |
|                                     | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|                                     | 29a. Certifier (Check one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                      |  |   |                                |  |
|                                     | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D09522</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>MARCH 29, 1999</b>   |
| State Registrar                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RICHARD SCHOENFELD, MD - 5530 WISCONSIN AVENUE, STE. 930 - CHEVY CHASE, MD. 20815</b>  |  |   |                                |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |  | 32. Registrar's Signature<br>   |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12158

|  |   |                                       |   |  |   |  |  |  |  |   |  |  |
|--|---|---------------------------------------|---|--|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Margaret P. Price   |                                       |   |  | 2. Date of Death<br>Month Day Year<br>March 24, 1999  |  |  |  | 3. Time of Death<br>12:45PM  |   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Rockville Nursing Home  |                                       |   |  | 4b. City, Town, or Location of Death<br>Rockville   |  |  |  | 4c. County of Death<br>Montgomery  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>578-18-8733  |                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>83 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 13, 1915       |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |   |  |  |
|  | Usual Residence of Decedent   |                                       |   |  |   |  |  |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  |                                       | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Derwood  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |  |
|  | 10e. Street and Number<br>7119 Grinnell Drive   |                                       |   |  | 10f. Zip Code<br>20855  |  | 10g. Citizen of What Country?<br>United States             |  |  |   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2   |                                       |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher's Aide   |  |  | 16b. Kind of Business/Industry<br>Montgomery County Public Schools |  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Thomas E. Plummer  |                                       |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Winifred Watkins   |  |  |  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Ronald D. Price/Son   |                                       |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7119 Grinnell Drive, Derwood, Maryland 20855   |  |  |  |  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parklawn Memorial Park  |  | Date<br>March 29, 1999  |  | 20c. Location - City or Town, State<br>Rockville, Maryland |  |  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>D. E. Perry  |                                       |   |  | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>Rockville, Inc. 300 West Montgomery Avenue<br>M00803 Rockville, Maryland 20850-2805                                       |  |  |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Hypertensive heart disease<br>Due to (or as a consequence of):<br>c. Chronic obstructive pulmonary disease<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                       |   |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Senile Dementia   |                                       |   |  |   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                       |   |  |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                       |   |  |   |  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred                                  |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                                       |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                                       |   |  |   |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>Thomas V. Joseph  |   |                                       |   | 29c. License number<br>D47330  |   | 29d. Date signed (Month, Day, Year)<br>3/24/99                                       |  |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Thomas V. Joseph, M.D. 50 W. Edmonston Drive, #207, Rockville, MD 20852  |   |                                       |   |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 31 1999   |   |                                       |   | 32. Registrar's Signature<br>B. Sparks                                       |   |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12159

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sam Boon Park

2. Date of Death

Month Day Year  
Mar 30, 1999

3. Time of Death

12:17am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

219-27-2125

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JULY 17, 1907

9. Birthplace (State or Foreign Country)

KOREA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3240 BIRCHTREE LANE

10f. Zip Code

20906

10g. Citizen of What Country?

KOREA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: KOREAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

HUNG JOON HAM

18. Mother's Name (First, Middle, Maiden Surname)

NUNG YI AHN

19a. Informant's Name/Relationship (Type, Print)

NOH PARK - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3340 BIRCHTREE LANE, SILVER SPRING, MARYLAND 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NORBECK MEMORIAL PARK

Date

4-2-99

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Cerebrovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&gt;2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rahul Gilotra MD

29c. License number

D32417

29d. Date signed (Month, Day, Year)

Mar 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rahul Gilotra Md 12016 Georgia Ave Wheaton Md 20902

State  
Registrar

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12160**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leonard J. Pastore, JR.

2. Date of Death

Month 3 Day 26 Year 99

3. Time of Death  
6 AM

4a. Facility Name (If not Institution, give street and number)

Mariner Health Care

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

108-36-6509

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 28, 1946

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

VA.

10b. County

Spotsylvania

10c. City, Town or Location

Fredericksburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

20005 Mill Garden Drive

10f. Zip Code

22407

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Contracting Officer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Leonard John Pastore Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Natalie Fontana

19a. Informant's Name/Relationship (Type, Print)

Valerie Pastore (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13517 Peakwood Lane Germantown, Md. 20874

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Mar. 29,  
1999

20c. Location - City or Town, State

Silver Spring, Md.

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

cardiac arrhythmia.

e. Due to (or as a consequence of):

Ischemic cardiomyopathy.

b. Due to (or as a consequence of):

IdDM.

c. Due to (or as a consequence of):

chronic renal insufficiency

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure.  
(R) Below knee amputation.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy  
performed?

☐ Yes ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

☐ Yes ☐ No

25. Was case referred to medical  
examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ajay Reddy MD.

29c. License number

D0053691

29d. Date signed (Month, Day, Year)

3/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AJAY REDDY, MD, Kaiser Permanente, Hollywood Hospital, 1500 Forest Glen Rd, Silver Spring MD.

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
 certificate.

To Be Completed by Funeral Director  
 To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Melissie Pemberton

2. Date of Death

Month Day Year  
March 27, 1999

3. Time of Death

7:41 am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

219-36-7665

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 25, 1907

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6208 MacArthur Boulevard

10f. Zip Code

20816

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Special Education

17. Father's Name (First, Middle, Last)

Not Available/ Collins

18. Mother's Name (First, Middle, Maiden Surname)

Not Available/ Musselman

19a. Informant's Name/Relationship (Type, Print)

Oakland H. Pemberton, Jr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13410 Hudson Place Bristow, Virginia 20136

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematorium or other place)


March 30, 1999

Montgomery Crematorium Inc.

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

 M00335

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue  
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d. Hypothyroidism

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

M

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

 H0051280 3-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANUSHIRAVAN DASGUPTA 13219 EXECUTIVE PARK TERRACE, CROFTON MD 21114

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12162**  
**Certificate of Death**

Reg. No.

|   |   |   |   |   |  |  |   |  |  |  |
|---|---|---|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ANNA SLEIGHTS PETERSON</b>                 |   |   |   |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>30</b> Year <b>1999</b> |  | 3. Time of Death<br><b>0613</b>                                |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>912 GABEL STREET</b> |   |   |   |  |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b>          |  | 4c. County of Death<br><b>MONTGOMERY</b>                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>042-09-1394</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>02 12 1910</b>              |  | 9. Birthplace (State or Foreign Country)<br><b>Connecticut</b> |  |
|   | Usual Residence of Decedent   |   |   |   |  |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Silver Spring</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>912 Gabel Street</b>   |   |   |   | 10f. Zip Code<br><b>20901</b>   |  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |  |  |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Michael Sleights</b>  |   |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fedosia Boska</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jo Ellen Glymph / Daughter</b>   |   |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>654 Providence Drive, Myrtle Beach, SC 29572</b> |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                       |  | 20c. Date<br><b>3-30-99</b>  |   | 20d. Location - City or Town, State<br><b>Alexandria, VA</b>                                   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |   |   |  | 22. Name and Address of Facility<br><b>Collins Funeral Home<br/>500 University Blvd West, Silver Spring, MD 20901</b>                                |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ARTERIOSECTOMIC CIRCULATORY DISEASE</b><br>Due to (or as a consequence of):<br><br>b. _____ Due to (or as a consequence of):<br><br>c. _____ Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |   |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |   |   |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |   |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |   |   |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |   |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |   |   |   |   |  | 29c. License number<br><b>015236</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 30, 1999</b>                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHIEF I. MARSHALL, MD 11125 ROCKVILLE PIKE, ROCKVILLE MD 20857</b>   |   |   |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |   | 32. Registrar's Signature<br> |   |   |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12163

|   |  |                           |   |   |   |  |   |  |
|---|--|---------------------------|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>RALPH LEE PFAU   |                           |   |   | 2. Date of Death<br>Month Day Year<br>MARCH 28, 1999  |  | 3. Time of Death<br>3:00 AM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>MONTGOMERY GENERAL HOSPITAL  |                           |   |   | 4b. City, Town, or Location of Death<br>OLNEY   |  | 4c. County of Death<br>MONTGOMERY   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>278 14 9949   |                           | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>91 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>AUG. 25, 1907  | 9. Birthplace (State or Foreign Country)<br>OHIO |
|   | Usual Residence of Decedent  |                           |   |   |   |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD.  | 10b. County<br>MONTGOMERY | 10c. City, Town or Location<br>SILVER SPRING  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br>1131 UNIVERSITY BLVD. #1204  |                           | 10f. Zip Code<br>20902  |   | 10g. Citizen of What Country?<br>UNITED STATES  |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 4  |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>COMPANY PRESIDENT                        |   | 16b. Kind of Business/Industry<br>BOTTLING COMPANY  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>DANIEL PFAU   |                           |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>EMMA WEICHEL   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>MARLENE A. WATERS, DAUGHTER  |                           |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3604 DELLABROOK ST., OLNEY, MD. 20832  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>METROPOLITAN CREMATORY  |   | Date<br>4/1/99  |  | 20c. Location - City or Town, State<br>ALEXANDRIA, VA.  |  |
|   | 21. Signature of Funeral Service Licensee<br>Muriel H. Barber  |                           |   |   | 22. Name and Address of Facility<br>MURIEL H. BARBER FUNERAL HOME<br>P.O. BOX 5038, LAYTONSVILLE, MD. 20882   |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>ACUTE MYOCARDIAL INFARCTION  |                           |   |   |   |  | Approximate Interval Between Onset and Death<br>IMMEDIATE   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |                           |   |   |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>FOOT INFECTION WITH CELLULITIS<br>CONGESTIVE HEART FAILURE<br>HYPOTHYROIDISM   |                           |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                           |   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |                           | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|   |  |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred   |  |   |  |
|   |  |                           |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                           |   |   |   |  | 29c. License number<br>D35045   |  |
| State<br>Registrar                            | 29b. Signature and title of certifier<br>Philip G. Henjum  |                           |   |   | 29d. Date signed (Month, Day, Year)<br>MARCH 28, 1999   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>PHILIP G. HENJUM, M.D., 3416 OLANDWOOD COURT, #204, OLNEY, MD. 20832   |                           |   |   |   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br>MAR 30 1999   |                           | 32. Registrar's Signature<br>S. Sparks  |   |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Richard M. Pfeiffer  |  |   |  | 2. Date of Death<br>Month Day Year<br>March 29, 1999   |  | 3. Time of Death<br>8:40 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Suburban Hospital  |  |   |  | 4b. City, Town, or Location of Death<br>Bethesda   |  | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director   | 5. Social Security Number<br>163-20-0556   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br>73 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 14, 1925                                 |  |
|   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery  |  | 10c. City, Town or Location<br>Chevy Chase   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>7208 Bybrook Lane   |  | 10f. Zip Code<br>20815   |  | 10g. Citizen of What Country?<br>United States                                       |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II Korea |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales  |  | 16b. Kind of Business/Industry<br>Publishing   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Wilbert George Pfeiffer   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bertha J. Crowe   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Patricia H. Pfeiffer/Wife  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7208 Bybrook Lane, Chevy Chase, Maryland 20815  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc.  |  | 20c. Location - City or Town, State<br>Bethesda, Maryland  |  | 20d. Date<br>March 31, 1999  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Robert A. Pumphrey</i> M00198  |  | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.<br>7557 Wisconsin Avenue<br>Bethesda, Maryland 20814-3501          |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Coronary Artery Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Ischemic Cardiomyopathy  |  |   |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br><i>Thomas G. Sinderson, M.D.</i>  |  |   |  | 29c. License number<br>D19144  |  | 29d. Date signed (Month, Day, Year)<br>March 29, 1999                                |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Thomas G. Sinderson, M.D. 6410 Rockledge Drive, Bethesda, Maryland 20817   |  |   |  |  |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>MAR 31 1999   |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12165

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Arabinda

N.

Phukan

2. Date of Death

Month

Day

Year

March 26, 1999

3. Time of Death

12:46 P.M.

4a. Facility Name (If not institution, give street and number)

4707 Tecumseh Street

4b. City, Town, or Location of Death

College Park

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-54-7152

6. Sex

XXM

2□ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 10, 1938

9. Birthplace (State or Foreign

India

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

XX Yes 2□ No

10e. Street and Number

4707 Tecumseh Street

10f. Zip Code

20740

10g. Citizen of What Country?

India

11. Marital Status

1□ Never Married

XX Married

3□ Widowed

4□ Divorced

12. Was Decedent Ever in U.S.

1□ Yes 2XX No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2XX No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Asian

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

self employed

17. Father's Name (First, Middle, Last)

Nilmoni

Phukan

18. Mother's Name (First, Middle, Maiden Surname)

Baku

Borthakur

19a. Informant's Name/Relationship (Type, Print)

Marilyn J. Phukan (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Lynnmoor Drive Silver Spring, MD. 20901

20e. Method of Disposition

1□ Burial

XX Cremation

3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory 3/28/1999

Date

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Road Beltsville, Maryland 20705

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Arteriosclerotic Cardiovascular Disease

e. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic alcoholism

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4XX Unknown

24a. Was an autopsy

performed?

Inspection

1□ Yes 2XX No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1□ Yes 2□ No

25. Was case referred to medical

examiner?

XX Yes 2□ No

26. Place of Death (Check only one)

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5XX Residence

6□ Other (Specify)

27. Manner of Death

XX Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending

Investigation

6□ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check only

one)

1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald V. Borgwardt

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R. Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12166

|  |  |   |   |   |  |  |  |  |
|--|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Odessa Poling</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 30, 1999</b>  |  | 3. Time of Death<br><b>10:20AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>CITIZENS NURSING HOME</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>FREDERICK</b>   |  | 4c. County of Death<br><b>FREDERICK</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-44-6004</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 2, 1910</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>WEST VIRGINIA</b>   |   | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>FREDERICK</b>  |  | 10c. City, Town or Location<br><b>MT. AIRY</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>12403 HILL COURT</b>   |   | 10f. Zip Code<br><b>21771</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BOOKKEEPER</b>                        |   | 16b. Kind of Business/Industry<br><b>ACCOUNTING</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>NEWTON THACHER COMPTON</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NELLIE SPRING</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LAURA PHAGAN/DAUGHTER</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12403 HILL COURT MT. AIRY, MD 21771</b>  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>NATIONAL MEMORIAL PARK</b>   |   | 20c. Date<br><b>04/03/99</b>   |  | 20d. Location - City or Town, State<br><b>FALLS CHURCH, VA.</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Anthony S. DeMay</b>   |   |   |   | 22. Name and Address of Facility<br><b>HINES-RINALDI FUNERAL HOME, INC.<br/>11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)<br/><b>Cardiac Arrest</b></p> <p>Due to (or as a consequence of):<br/><b>Heart Failure</b></p> <p>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br/> <div style="border-left: 2px solid black; padding-left: 10px;"> <b>Respiratory Failure</b><br/> <b>Bilateral pneumonia</b> </div> </p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death<br/> <b>minutes</b><br/> <b>hours-days</b><br/> <b>hours-days</b><br/> <b>Days</b> </p> </div> </div> |   |   |   |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Dementia</b>  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how Injury occurred   |   |   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>MD 026499</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3-30-99</b> |  |  |  |  |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><b>Ronald Miller 12345 Main St</b>   |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene **99 12167**  
**Certificate of Death**

Reg. No.

|  |  |   |  |  |   |  |   |  |
|--|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Kenneth George Polley</b>                               |   |  |  | 2. Date of Death<br>Month Day Year<br><b>March 30, 1999</b> |  | 3. Time of Death<br><b>6:25 PM</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Washington Adventist Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>  |  | 4c. County of Death<br><b>Montgomery</b>                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-52-7139</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 24, 1926</b> | 9. Birthplace (State or Foreign Country)<br><b>Gibraltar (UK)</b>  |
|  | Usual Residence of Decedent  |   |  |  |   |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>806 Wayne Avenue</b>  |  |   |  | 10f. Zip Code<br><b>20910-4426</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>2</b>  |  |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Optician</b>   |   | 16b. Kind of Business/Industry<br><b>Owner Optical Business</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>George S. Polley</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beatrice Davison</b>   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Eugenie M. Polley (wife)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10</b>   |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>  |   | Date<br><b>3-31-99</b>   |   | 20c. Location - City or Town, State<br><b>Beltsville, Maryland</b>   |
| 21. Signature of Funeral Service Licensee<br><i>Eugenie M. Polley</i>  |  |   |  | 22. Name and Address of Facility<br><b>Rapp Funeral Services, P. A.<br/>933 Gist Avenue, Silver Spring, MD 20910</b>   |   |  |   |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Hypoxia</b><br>Due to (or as a consequence of):<br><br>b. <b>Aspiration pneumonia</b><br>Due to (or as a consequence of):<br><br>c. <b>respiratory failure</b><br>Due to (or as a consequence of):<br><br>d. <b>Alzheimer disease</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |   | Approximate Interval Between Onset and Death<br><br><b>2-3 days</b><br><br><b>3 weeks</b><br><br><b>3 weeks</b><br><br><b>Yrs.</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>history of stroke</b>   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how Injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>Rashid Baghai</i>   |  | 29c. License number<br><b>D39372</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>31 March 1999</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>324 University Road West Suit 324<br/>Silver Spring, MD 20901<br/>Rashid Baghai-Naini, M. D.</b>  |  |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |  | 32. Registrar's Signature<br><i>Geneva B. Sparks</i>  |  |  |   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12168

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Pearl Lee Prince  |  |   |  | 2. Date of Death<br>Month Day Year<br>March 28, 1999  |  |   |  | 3. Time of Death<br>4:58 A.M.  |  |  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital   |  |   |  | 4b. City, Town, or Location of Death<br>Silver Spring   |  |   |  | 4c. County of Death<br>Montgomery  |  |  |  |  |  |
| 5. Social Security Number<br>578-01-4235  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>83 Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br>June 23, 1915   |  | 9. Birthplace (State or Foreign Country)<br>South Carolina |  |
| Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Silver Spring  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |  |
| 10e. Street and Number<br>8201 16th Street  |  |   |  | 10f. Zip Code<br>20910  |  |   |  | 10g. Citizen of What Country?<br>United States   |  |  |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                 |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerk  |  |   |  | 16b. Kind of Business/Industry<br>Federal Government   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Joseph Prince  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Janie Buchanan   |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Jan Hall (Niece)  |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>917 Aspen Street, N.W., Washington, D.C. 20012 |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Harmony Memorial Park   |  | Date<br>4/2/99  |  | 20c. Location - City or Town, State<br>Landover, Maryland  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Thomas G. Clyburn  |  |   |  | 22. Name and Address of Facility<br>McGuire Funeral Service, Inc.<br>7400 Georgia Ave. N.W., Washington, D.C. 20012   |  |   |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sepsis<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Renal Failure<br>Malnutrition<br>Anasarca |  |   |  |   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death               |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Renal Failure<br>Malnutrition<br>Anasarca   |  |   |  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>G. Chablan MD  |  |   |  | 29c. License number<br>D42578   |  |   |  | 29d. Date signed (Month, Day, Year)<br>MAR 30, 1999  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Gul G. Chablan MD 1119 Rockville PK #316 Rockville MD 20852   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999  |  |   |  | 32. Registrar's Signature<br>B. Sparks  |  |   |  |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

State  
Registrar



JAMES ODELL PORTER

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27 PER MEO G771 5-11-99 WR.

## Certificate of Death

Reg. No.

99 12169

|  |  |   |  |  |  |  |   |  |  |  |  |
|--|--|---|--|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>James Odell Porter                     |   |  |  | 2. Date of Death<br>Month Day Year<br>MARCH 26, 1999 |  |   |  | 3. Time of Death<br>0517 AM                          |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>20314 BRENT LANE |   |  |  | 4b. City, Town, or Location of Death<br>CALLAWAY     |  |   |  | 4c. County of Death<br>ST. MARY'S                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-49-2758   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>2 Yrs.             |  | 8. Date of Birth (Month, Day, Year)<br>January 17, 1997 |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |  |
|  | Usual Residence of Decedent  |   |  |  |  |  |   |  |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>St. Mary's   |  | 10c. City, Town or Location<br>Callaway  |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br>20314 Brent Lane   |  |   |  | 10f. Zip Code<br>20620   |  |  |   | 10g. Citizen of What Country?<br>United States   |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>N/A   |  |  |   | 16b. Kind of Business/Industry<br>N/A  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>James Edward Porter   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Tammy Cofield   |  |  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>James E. Porter, Father  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>20314 Brent Lane, Callaway, Maryland 20620  |  |  |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Charles Memorial Gardens  |  | 20c. Date<br>3/30/99   |  | 20d. Location - City or Town, State<br>Leonardtwn, Maryland                          |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><br>Edward N. Brinsfield, Jr. M00052  |  |   |  | 22. Name and Address of Facility<br>Brinsfield Funeral Home, P.A.<br>22955 Hollywood Road, Leonardtown, MD 20650   |  |  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. VIRAL SYNDROME<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |   |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br><br>Joseph Pestaner, M.D.   |  |   |  | 29c. License number<br>O.C.M.E   |  |  |   | 29d. Date signed (Month, Day, Year)<br>MARCH 26, 1999  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |  |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 28 1999   |  | 32. Registrar's Signature<br>   |  |  |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

89 12170

|  |   |  |   |  |  |   |  |                                   |   |  |
|--|---|--|---|--|--|---|--|-----------------------------------|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Jane Pleasant</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>27</b> Year <b>1999</b>  |   |  |                                   | 3. Time of Death<br><b>5:45 p.m.</b>                                    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>467 Colonial Ridge Lane</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Arnold</b>  |   |  |                                   | 4c. County of Death<br><b>Anne Arundel</b>                              |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-28-2464</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.   |   | If Under 1 Year<br>Months Days                             |                                   | If Under 24 Hrs.<br>Hours Min.  |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>May 8, 1932</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Anne Arundel</b>                         |                                   | 10c. City, Town or Location<br><b>Arnold</b>                            |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>467 Colonial Ridge Lane</b>  |  |  |   | 10f. Zip Code<br><b>Arnold</b>                             |                                   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   |  |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   |  |                                   | 16b. Kind of Business/Industry<br><b>Home</b>                           |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Walter K. Rowe, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel (Unknown)</b>  |   |  |                                   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>James H. Pleasant / husband</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>467 Colonial Ridge Lane, Arnold, MD 21012</b>  |   |  |                                   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial</b>   |  | Date<br><b>Mar 30 1999</b>   |   | 20c. Location - City or Town, State<br><b>Elkridge, MD</b> |                                   |   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral</b><br><b>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>  |   |  |                                   | Home  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Breast Cancer metastatic</b><br>Due to (or as a consequence of):<br><b>b. To Liver and Bone</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>11 years</b>  |   |  |                                   |   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |                                   |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |                                   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA             |   | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |                                   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br> |   | 29c. License number<br><b>027938</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/24/99</b>                                       |  |                                   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mayer Gorbach, MD 795 Aqueduct Rd. Glen Burnie, MD 21061</b>  |   |  |   |  |  |   |  |                                   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |   | 32. Registrar's Signature<br>            |   |  |  |   |  |                                   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

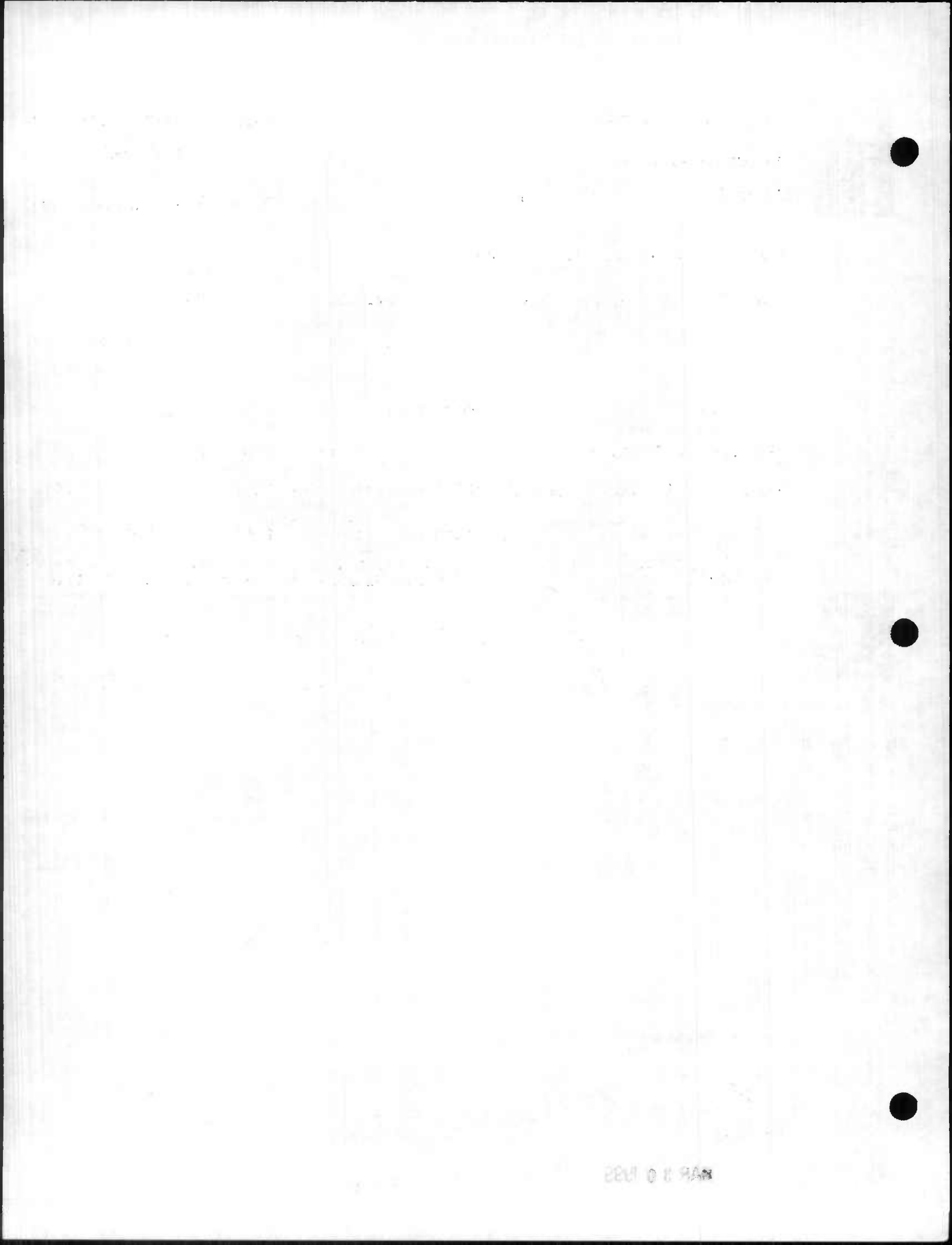
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



MAR 30 1982

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12171

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GALLOWAY Lee PARKER JR

2. Date of Death

March 24 99

3. Time of Death

2255 AM

4a. Facility Name (If not institution, give street and number)

Annapolis Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

212-52-2682

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

3-6-48

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

19 Carver street

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

E.L. Gardner

17. Father's Name (First, Middle, Last)

GALLOWAY L. PARKER SR.

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Hunt

19a. Informant's Name, Relationship (Type, Print)

Chandra Parker (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 Metispa Drive Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Annapolis Mem

Date

3/30/99

20c. Location - City or Town, State

Annapolis, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

House of Hicks F/H 1922 Forest Drive Annapolis, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Gram  $\ominus$  Septicemia

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

sickle cell anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

019838

29d. Date signed (Month, Day, Year)

3/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart E. Selonich, M.D. 900 Bostgate Rd. Annapolis, Md 21401

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12172

|   |  |                                |   |   |  |  |  |  |  |
|---|--|--------------------------------|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Winifred V. Peterson</b>                    |                                |   |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 25 1999</b>   |  | 3. Time of Death<br><b>21:43</b>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b> |                                |   |   | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |  | 4c. County of Death<br><b>ALLEGANY</b>   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-10-4580</b>  |                                | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug 7, 1917</b>                    |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|   | Usual Residence of Decedent  |                                |   |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Allegany</b> |   | 10c. City, Town or Location<br><b>Mt. Savage</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>12718 Jealous Row</b>  |  |                                |   | 10f. Zip Code<br><b>21545</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                                  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |                                |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>retired</b> |  | 16b. Kind of Business/Industry<br><b>textile</b>                             |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alfred T. Crutchley</b>   |  |                                |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Effie P (Karnes)</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Peggy Trimble daughter</b>   |  |                                |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12718 Jealous Row; Mt. Savage, MD 21545</b>  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Restlawn Memorial Gard</b>   |   | 20c. Location - City or Town, State<br><b>3/29/ LaVale, MD</b>   |  | 20d. Date  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>James J Scarpelli</b>   |  |                                |   |   | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home P.A. Cumberland, Maryland 21502</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br><br>b. <b>CHRONIC LUNG DISEASE</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                |   |   |  |  |  | Approximate Interval Between Onset and Death<br><br><b>2 WEEKS</b><br><br><b>25 YEARS</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |                                | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |  |
| 28d. Describe how injury occurred   |  |                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner  |  |                                | 29b. Signature and title of certifier<br><b>DR. W. GUY FISCUS</b>   |   |  |  |  |  |  |
| 29c. License number<br><b>D 12779</b>   |  |                                | 29d. Date signed (Month, Day, Year)<br><b>3/28/99</b>   |   |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. W. GUY FISCUS, MEMORIAL MEDICAL BUILDING, 500 MEMORIAL AVE., CUMBERLAND, MD</b>  |  |                                |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  |                                | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12173

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Sherman Robert Parker  |   |  |  | 2. Date of Death<br>Month Day Year<br>MARCH 23 1999  |  | 3. Time of Death<br>12:20 PM                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>MEMORIAL HOSPITAL MEDICAL CENTER   |   |  |  | 4b. City, Town, or Location of Death<br>CUMBERLAND   |  | 4c. County of Death<br>ALLEGANY                                  |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-10-1347   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>79 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Sept. 1, 1919             |  |
|  | 9. Birthplace (State or Foreign Country)<br>MD   |   | 10a. State<br>MD   |  | 10b. County<br>Allegany  |  | 10c. City, Town or Location<br>Cumberland                        |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 10e. Street and Number<br>434 Pine Ave.  |  | 10f. Zip Code<br>21502   |  | 10g. Citizen of What Country?<br>USA                             |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW11 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer                                       |  | 16b. Kind of Business/Industry<br>Railroad   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Robert Parker   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carrie Courtney   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Dorothy D. Parker (wife)   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>434 Pine Ave. Cumberland, Md. 21502   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Md. Veterans Cemt. Rocky Gap   |  | 20c. Location - City or Town, State<br>3/26/99 Flintstone, MD  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Robert C. Adams</i>  |   |  |  | 22. Name and Address of Facility<br>Merritt-Adams Funeral Home<br>404 Decatur St. Cumberland, Md. 21502  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>CEREBROVASCULAR ACCIDENT<br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |   |  |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |  |  |  |  | Approximate Interval Between Onset and Death<br>1 WEEK           |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |   |  | 29c. License number<br>D 36766   |  | 29d. Date signed (Month, Day, Year)<br>March 24, 1999                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>VIK POONAI M.D., 920 NATIONAL HIGHWAY, LAVALE MD 21502   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 25 1999   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |  |





Amended #1 4/1/99, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12174

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Funeral  
Director

Physician  
/Medical  
Examiner

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>HILDA <sup>Maria</sup> MARIA PETERSON</b>  |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>27</b> Year <b>1999</b>  |                                | 3. Time of Death<br><b>8:35 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |                                | 4c. County of Death<br><b>Allegany</b>   |  |
| 5. Social Security Number<br><b>214-52-1515</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br><b>NOV 23, 1949</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |  |  |                                |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Cumberland</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>457 Goethe Street</b>  |  |   |  | 10f. Zip Code<br><b>21502</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b> Elementary/Secondary (0-12) <b>College</b> (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>homemaker</b>  |                                | 16b. Kind of Business/Industry<br><b>own home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ellis Augustus Rose</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hilda A (Grabenstein)</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William G. Peterson husband</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>457 Goethe Street; Cumberland, MD 21502</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rocky Gap Veterans Cem3/30/ Flintstone, MD</b>   |  | Date   |                                | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br><b>Nicholas J. Scarpelli</b>   |  |   |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home P.A. Cumberland, Maryland 21502</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Compassion of both Atanin</b><br>Due to (or as a consequence of):<br><br>b. <b>Metastatic Chondrosarcoma</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><b>1 year</b> |  |   |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><b>John Mehanna</b>  |  |   |  | 29c. License number<br><b>D-17526</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>MARCH 30, 1999</b>   |  |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><b>John Mehanna, M.D., 909-Bseton Drive, Cumberland, MD 21502</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>   |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |                                |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12175**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPHINE PRATT

2. Date of Death

Month Day Year  
April 2, 1999

3. Time of Death

6:00 a.m.

4e. Facility Name (If not institution, give street and number)

13708 CECIL AVENUE

4b. City, Town, or Location of Death

CRESAPTOWN

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

217-74-1487

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 9, 1897

9. Birthplace (State or Foreign Country)

Brazil

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cresaptown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13708 Cecil Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Bruno Pascuzzi

18. Mother's Name (First, Middle, Maiden Surname)

Carmella (nmn)

19a. Informant's Name/Relationship (Type, Print)

Thomas Pratt--son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14805 Shady Brook Lane; Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

04/05

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardio - pulmonary embolism

Due to (or as a consequence of):

b. C. H F

Due to (or as a consequence of):

c. Aortic stenosis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1/2 hr

5 yrs

25 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No released

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Uriel Velandia

29c. License number

D08377

29d. Date signed (Month, Day, Year)

April 5, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Uriel Velandia; 902 Seton Drive; Cumberland, MD 21502

31. Date filed (Month, Day, Year)

APR 05 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

MS

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12176

|  |   |   |  |   |   |   |  |  |  |
|--|---|---|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Edward Douglas Pitcher, Jr.</b>                  |   |  |   | 2. Date of Death<br>Month Day Year<br><b>March 27, 1999</b> |   | 3. Time of Death<br><b>4:30 pm</b>                         |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>                 |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-26-0738</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb 15, 1931</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                     |   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Anne Arundel</b>                          |   | 10c. City, Town or Location<br><b>Jessup</b>               |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>2021 Orchard Avenue</b>  |   | 10f. Zip Code<br><b>20794</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 8</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Foreman</b>   |  | 16b. Kind of Business/Industry<br><b>Cooling Towers</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Edward Douglas Pitcher</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gladys H. Bolden</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Iva Mae Pitcher /spouse</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 73, Jessup, Maryland 20794</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Pk</b>                                |  | 20c. Location - City or Town, State<br><b>3/30/99 Dorsey, Maryland</b>       |  |
| 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707-4389</b>  |  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>f. Chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):<br><br>g.<br>Due to (or as a consequence of):<br><br>h. |   | Approximate Interval Between Onset and Death<br><b>30 min.</b>  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive pulmonary disease</b>   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D29888</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1999</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David Leichtling, M.D. 2 Knoll North, Columbia, Maryland 21045</b>  |   | 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |  | 32. Registrar's Signature<br>   |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12177

|   |   |  |  |  |   |                                |  |   |
|---|---|--|--|--|---|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT HOWARD PATTERSON</b>  |  |  |  | 2. Date of Death<br>Month <b>03</b> Day <b>30</b> Year <b>1999</b>  |                                | 3. Time of Death<br><b>4:04 Am</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Atlantic General Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Berlin</b>   |                                | 4c. County of Death<br><b>Worcester</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>176-10-9556</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>June 10 1919</b>   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |
|   | Usual Residence of Decedent   |  |  |  | 10a. State<br><b>MD</b>   |                                | 10b. County<br><b>Worcester</b>  |   |
| To Be Completed by Funeral Director   | 10c. City, Town or Location<br><b>Berlin</b>  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                | 10e. Street and Number<br><b>106 Esham Ave.</b>  |   |
|   | 10f. Zip Code<br><b>21811</b>   |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |                                | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
|   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates <b>1944-46</b>   |  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>mechanic</b>  |                                | 16b. Kind of Business/Industry<br><b>auto repair</b>   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Clarence Leroy Patterson</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katherine Elbert</b>  |                                |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Anna Lee Patterson-wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>106 Esham Ave., Berlin MD 21811</b>   |                                |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cemetery 4-2-99 Hurlock Md.</b>  |                                | 20c. Location - City or Town, State  |   |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Thomas Funeral Home PA<br/>700 Locust St. Cambridge, MD 21613</b>  |                                |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. <u>pneumonia</u></b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. _____</b><br>Due to (or as a consequence of):<br><b>c. _____</b><br>Due to (or as a consequence of):<br><b>d. _____</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>3 weeks</b>  |                                |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>chronic obstructive pulmonary disease</b>  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |                                |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |   |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>  |   |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 28d. Describe how injury occurred   |                                |  |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |   |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br><br><b>physician</b>  |                                |  |   |
| State Registrar   | 29c. License number<br><b>H44283</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>3/30/99</b>   |                                |  |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert Durkin 9733 Heathway Drive Berlin, MD</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>   |                                |  |   |
| 32. Registrar's Signature<br> |   |  |  |  |   |                                |  |   |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12178

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE F. QUILLEN

2. Date of Death  
Month Day Year  
MARCH 24, 19993. Time of Death  
11:15 PM

4a. Facility Name (If not institution, give street and number)

MANOR CARE HEALTH SERVICE

4b. City, Town, or Location of Death

CHEVY CHASE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

133-05-6368

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 14, 1919

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

CHEVY CHASE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8824 BRIERLY RD.

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

MAX NATHAN FEIGENBAUM

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE REISER

19a. Informant's Name/Relationship (Type, Print)

PAUL QUILLEN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6342 ROAN STALLION LA., COLUMBIA, MD. 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ARLINGTON NATIONAL CEM.

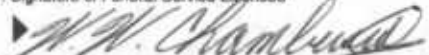
Date

4/1/99

20c. Location - City or Town, State

ARLINGTON, VA.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

m00091 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 MONTHS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RIGHT BELOW THE KNEE AMPUTATION

DIABETES MELLITUS

CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D 51015

29d. Date signed (Month, Day, Year)

March 25 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ellen Pinhour 5530 Wisconsin Ave Suite #1045 Chevy Chase, MD

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12179

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE E. RICHARD

2. Date of Death

Month Day Year  
March 30 1999

3. Time of Death

7:32 pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Nursing & Rehabilitation

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

026-01-8648

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 17 1909

9. Birthplace (State or Foreign Country)

MA

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8314 14th Avenue, Apt #302

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edmond Fontaine

18. Mother's Name (First, Middle, Maiden Surname)

Elmina Labonte

19a. Informant's Name/Relationship (Type, Print)

Doris E. Richard

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8314 14th Ave., Apt 301, Hyattsville, MD 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

4-5-99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

*Tracy A. Stuever*

22. Name and Address of Facility

Collins Funeral Home  
500 University Blvd W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Respiratory failure*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 HR.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Aspiration Pneumonia*  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*A. Chacko*

29c. License number

220129

29d. Date signed (Month, Day, Year)

3/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. CHACKO, 7610 Carroll Ave # 390, Takoma Park, MD 20912

State  
Registrar

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

*B. Sparks*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12180

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |  |  |
|---|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>ROMAINE FRANCES ROBINSON  |   |   |   | 2. Date of Death<br>Month Day Year<br>March 24, 1999   |  | 3. Time of Death<br>7:50AM                                       |
|   | 4a. Facility Name (If not institution, give street and number)<br>HCR Manor Care  |   |   |   | 4b. City, Town, or Location of Death<br>Chevy Chase  |  | 4c. County of Death<br>Montgomery                                |
| Funeral<br>Director   | 5. Social Security Number<br>579 30 5212  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>73 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>June 8, 1925   | 9. Birthplace (State or Foreign Country)<br>Virginia             |
|   | Usual Residence of Decedent   |   |   |   |  |  |  |
| To Be Completed by Funeral Director   | 10e. State<br>N/A   | 10b. County<br>N/A  | 10c. City, Town or Location<br>Washington, D.C.   |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 10e. Street and Number<br>1900 Tulip Street, N.W.   |   |   | 10f. Zip Code<br>20012  |  | 10g. Citizen of What Country?<br>United States   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+  |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Assistant Principal                      |   | 16b. Kind of Business/Industry<br>Montgomery County School System  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Oscar C. Scott   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Julia Archer   |  |  |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br>Peter L. Robinson, Jr./Spouse   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1900 Tulip Street, N.W. Washington, D.C. 20012 |  |  |  |
|   | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery   |   | Date<br>3/29/99  | 20c. Location - City or Town, State<br>Brentwood, MD   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br>McGuire Funeral Service, Inc. 20012<br>7400 Georgia Avenue, N.W. Washington, D.C.                                 |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |   |   |   |  |  |  |
|   | Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br>e. Cerebrovascular Accident<br>Due to (or as a consequence of):<br>b. Hypertension<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes mellitus, Bilateral deep venous thrombosis,<br>Congestive heart failure  |   |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred   |   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br>Ellen m Pinholt MD   |   | 29c. License number<br>D 51015  |   | 29d. Date signed (Month, Day, Year)<br>March 25, 1999   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Ellen Pinholt 5530 Wisconsin Ave Suite #1045 Chevy Chase, MD  |   |   |   |   |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>MAR 29 1999  |   | 32. Registrar's Signature<br>   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12181

Physician  
/Medical  
Examiner

Funeral  
Director

|   |    |   |  |  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
|---|----|---|--|--|--|---|--|--|--|---|----|-----------------------------|--|----|-------------------------------------|----|------------------|----|---------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Morris Roche</b>   |    |   |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>28</b> Year <b>1999</b>                       |  | 3. Time of Death<br><b>11:35 AM</b>  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |    |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 5. Social Security Number<br><b>172-05-0915</b>   |    | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>August 3 1914</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| Usual Residence of Decedent   |    |   |  |  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 10a. State<br><b>MD</b>   |    | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 10e. Street and Number<br><b>1001 Spring Street</b>   |    |   |  | 10f. Zip Code<br><b>20910</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1941-1945</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |    |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Circulation Department</b>   |  | 16b. Kind of Business/Industry<br><b>Washington Star</b>                                    |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 17. Father's Name (First, Middle, Last)<br><b>David Roche</b>   |    |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dora (Unknown)</b>                  |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Molly Roche/Wife</b>   |    |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1001 Spring Street, Silver Spring, MD 20910</b>  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |    |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Congregation Degel Israel Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>3/30/99 Lancaster, PA</b>                         |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 21. Signature of Funeral Service Licensee<br>   |    |   |  | 22. Name and Address of Facility<br><b>Takoma Funeral Home<br/>254 Carroll St., Washington, DC 20012</b>   |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |    |   |  |  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| <table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td><b>Acute Cardiac Injury</b></td> <td rowspan="4">                 Due to (or as a consequence of):<br/><br/>                 Due to (or as a consequence of):<br/><br/>                 Due to (or as a consequence of):<br/><br/>                 Due to (or as a consequence of):             </td> </tr> <tr> <td>b.</td> <td><b>Acute Gastrointestinal Bleed</b></td> </tr> <tr> <td>c.</td> <td><b>Arteritis</b></td> </tr> <tr> <td>d.</td> <td><b>Coagulopathy</b></td> </tr> </table> |    |   |  |  |  |   |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Acute Cardiac Injury</b> | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): | b. | <b>Acute Gastrointestinal Bleed</b> | c. | <b>Arteritis</b> | d. | <b>Coagulopathy</b> |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. | <b>Acute Cardiac Injury</b>   | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
|   | b. | <b>Acute Gastrointestinal Bleed</b>   |  |  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
|   | c. | <b>Arteritis</b>  |  |  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
|   | d. | <b>Coagulopathy</b>   |  |  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |    |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |    |                             |  |    |                                     |    |                  |    |                     |
|   |    |   |  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
|   |    |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |    | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |    | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
|   |    |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |    |   |  |  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 29b. Signature and title of certifier<br>   |    |   |  | 29c. License number<br><b>D50637</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/28/99</b>                                       |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shakun Malik, MD 5554 Wisconsin Ave., Chevy Chase, MD 20815</b>  |    |   |  |  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |    |   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |   |    |                             |  |    |                                     |    |                  |    |                     |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12182

Certificate of Death

Reg. No.

|   |   |   |  |   |   |   |  |  |
|---|---|---|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARY ROE</b>                                       |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1999</b> |   | 3. Time of Death<br><b>10:19 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Laurel Regional Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Laurel</b>                 |   | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>226-42-6473</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>May 21, 1931</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |
|   | Usual Residence of Decedent   |   |  |   |   |   |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Severn</b>  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>8209 Autumn Lake Court</b>   |   |   |  | 10f. Zip Code<br><b>21144</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |   |   | 16b. Kind of Business/Industry<br><b>Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William Jackson (Son)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8351 Candlewick Ct., Severn, MD 21144</b>   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Annapolis Mem. Gardens</b>   |  |   | Date<br><b>4/2/99</b>   |   | 20c. Location - City or Town, State<br><b>Annapolis, MD</b>                                    |  |
| 21. Signature of Funeral Service Licensee<br><i>George R. Snowden</i>   |   |   |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hypoxia</b><br><br>Due to (or as a consequence of):<br><b>Respiratory Failure</b><br><br>Due to (or as a consequence of):<br><b>Few days</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Few mnts.</b> |   |   |  |   |   |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DICA</b><br><b>Sepsis</b><br><b>CAD</b>  |   |   |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  | 29b. Signature and title of certifier<br><i>Frank M. D. Attending</i>   |   | 29c. License number<br><b>042580</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/27/99</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>P. S. AUTLA 5632 Annapolis Rd. #13 BLADENBURG MD 20710</b>   |   |   |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |   | 32. Registrar's Signature<br><i>Benjamin B. Sparks</i>  |  |   |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |  |   |  |   |  |  |  |  |
|---|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LILLIAN W. ROTHBARD</b>                                     |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 26 1999</b>                 |  | 3. Time of Death<br><b>10:20AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HEBREW HOME OF GREATER WASHINGTON</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>                   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579 52 5406</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>FEB 28, 1907</b>   | 9. Birthplace (State or Foreign Country)<br><b>MASSACHUSETTS</b>   |
|   | Usual Residence of Decedent  |   |  |   |  |  |  |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>SILVER SPRING</b>   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10a. Street and Number<br><b>1131 UNIVERSITY BLVD. W. #509</b>  |  |   |  | 10f. Zip Code<br><b>20902</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ADMINISTRATOR</b>   |  |  | 16b. Kind of Business/Industry<br><b>UNITED STATES GOVERNMENT</b>                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>CHARLES WEINSTEIN</b>   |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARAH KRITCHER</b> |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CHARLES ROTHBARD (SON)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1131 UNIVERSITY BLVD. W. #509-SILVER SPRING, MD. 20902</b>  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JUDEAN MEMORIAL GDNS.</b>  |  | 20c. Location - City or Town, State<br><b>3/28/99 OLNEY, MARYLAND</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>MITRAL REGURGITATION</b><br>Due to (or as a consequence of):<br>c. <b>HYPERTENSIVE CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br>d. <b>HYPERTENSION</b> |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>5 YEARS</b><br><b>1 YEARS</b><br><b>YEARS</b><br><b>YEARS</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                             |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D05885</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>03/26/99</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE</b>  |  |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12184

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia Ann Rutledge</b>   |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>24</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>9:40P.</b>                     |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Doctor's Community Hospital</b>   |   |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |  | 4c. County of Death<br><b>Prince George's</b>         |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>411-78-2581</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 30, 1949</b>                                    |
|   | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b>   |   |  |   |  |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |   |  |   |  |   |  |
|   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince George's</b>  |   | 10c. City, Town or Location<br><b>Landover</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 10e. Street and Number<br><b>1801 Bellhaven Drive, #302</b>  |   |  | 10f. Zip Code<br><b>20785</b>   |  | 10g. Citizen of What Country?<br><b>United States</b> |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                              |  | 16b. Kind of Business/Industry<br><b>own home</b>     |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Thomas Franklin Swafford</b>   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruby Hall</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Brenda A. Cavanaugh (daughter)</b>  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21061 106 North Hollins Ferry Rd. Ferndale, Maryland</b> |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mountain View Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>3/28/1999 Benton, Tennessee</b>  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Donald V. Borgwardt</b>  |   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>                     |  |   |  |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |   |  |   |  |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. Dissected Intravascular Coagulation hours</b><br>Due to (or as a consequence of):<br><b>b. Hepatic Encephalopathy hours</b><br>Due to (or as a consequence of):<br><b>c. Fulminant Hepatic Failure Weeks</b><br>Due to (or as a consequence of):<br><b>d. Alcoholic Liver Disease Years</b>   |   |  |   |  |   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Aspiration Pneumonia</b><br><b>Sepsis Syndrome</b>  |   |  |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |   |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |   |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |   |  |   |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |   |  |
|   | 29b. Signature and title of certifier<br><b>K. Michael Lyons MD</b>  |   | 29c. License number<br><b>00052865</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 25, 1999</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KELSON FIGARO, 7202 OLIVINBERRY WAY, BOWIE, MD 20720</b> |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  | 32. Registrar's Signature<br><b>B. Sparks</b> |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12185

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Harry Rutt

2. Date of Death

Month Day Year  
April 4, 1999

3. Time of Death

6:32 a.m.

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

37770 Mohawk Drive

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Mary's

5. Social Security Number

215-36-3691

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 10, 1936

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

37770 Mohawk Drive

10f. Zip Code

20622

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cattle Trucker

16b. Kind of Business/Industry

Livestock

17. Father's Name (First, Middle, Last)

Harry Edwin Rutt

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Erline

19a. Informant's Name/Relationship (Type, Print)

Margaret Rutt, Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 11, Charlotte Hall, Maryland 20622

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Trinity Memorial Gardens

Date

4-8-99

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

Ronald L. Thompson, Jr. M01154

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.  
22955 Hollywood Road, Leonardtown, MD 2065023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Leon Berube, M.D.

29c. License number

D0000506

29d. Date signed (Month, Day, Year)

April 5, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Leon Berube, M.D.

28170 Old Village Road, Mechanicsville, Maryland 20659

State  
Registrar

31. Date filed (Month, Day, Year)

APR 7 1999

32. Registrar's Signature

Berube B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12186  
Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |                                |  |  |
|--|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Dorothy Virginia Raley   |  |   |   | 2. Date of Death<br>Month Day Year<br>April 3, 1999  |                                | 3. Time of Death<br>7:56 AM  |  |
| 4a. Facility Name (If not institution, give street and number)<br>24485 Mervel Dean Road   |  |   |   | 4b. City, Town, or Location of Death<br>Hollywood  |                                | 4c. County of Death<br>St. Mary's  |  |
| 5. Social Security Number<br>214-60-3023   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>80 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>July 19, 1918   |  |
| 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |   |  |                                |  |  |
| Usual Residence of Decedent  |  |   |   |  |                                |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>St. Mary's   |   | 10c. City, Town or Location<br>Hollywood   |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br>24485 Mervel Dean Road   |  |   |   | 10f. Zip Code<br>20636   |                                | 10g. Citizen of What Country?<br>U.S.A.  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12th   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |                                | 16b. Kind of Business/Industry<br>Own Home   |  |
| 17. Father's Name (First, Middle, Last)<br>John Martin Wible   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ella N. Woodley   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Robert Garner/Son  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>45973 Clarks Road, California, MD 20619   |                                |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. John's Cemetery   |   | Date<br>4/6/99   |                                | 20c. Location - City or Town, State<br>Hollywood, MD   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael J. Gardiner</i>  |  |   |   | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, MD 20650  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Cerebro-vascular Accident<br>Due to (or as a consequence of):<br>b. Coronary Artery disease<br>Due to (or as a consequence of):<br>c. Diabetes mellitus<br>Due to (or as a consequence of):<br>d. peripheral Neuropathy<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |                                |  |  |
| Approximate Interval Between Onset and Death<br>5 yrs<br>5 yrs<br>Sudden<br>10 yrs   |  |   |   |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |   |  |                                | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |   |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |                                |  |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |                                |  |  |
| 29b. Signature and title of certifier<br><i>Dr. K. Shah</i>  |  |   |   | 29c. License number<br>D15032 - MD   |                                | 29d. Date signed (Month, Day, Year)<br>4/6/99  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Vinod K. Shah, MD Philip J. Bean Bldg.<br>24035 Three Notch Road<br>Hollywood, MD 20636  |  |   |   |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br>ADD 7 1999  |  |   |   | 32. Registrar's Signature<br><i>Benita B. Sparks</i>   |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Item#5 perFH G770 4/14/99 EW

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Calvin E. Ripken, Sr.

2. Date of Death

Month  
MARCHDay  
25Year  
1999

3. Time of Death

04:05 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

5. Social Security Number

215-32-7491

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 17, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

410 Clover Street

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Professional Baseball

16b. Kind of Business/Industry

Sports

17. Father's Name (First, Middle, Last)

Arend Ripken

18. Mother's Name (First, Middle, Maiden Surname)

Clara Oliver

19a. Informant's Name/Relationship (Type, Print)

Violet R. Ripken (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

410 Clover Street, Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Baker Cemetery

Date

3/30/99

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Service Licensee

Kenneth B. Cargle

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-339923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. hyperventilation

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. small cell cancer of the lung

Due to (or as a consequence of):

months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

deep vein thrombosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chris Parsons, M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

March 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chris H. Parsons Tower 110 Johns Hopkins Hospital 600 N. Wolfe Street,

Baltimore, Maryland  
21287

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

B. Parsons

Baltimore, Maryland 21215-0020

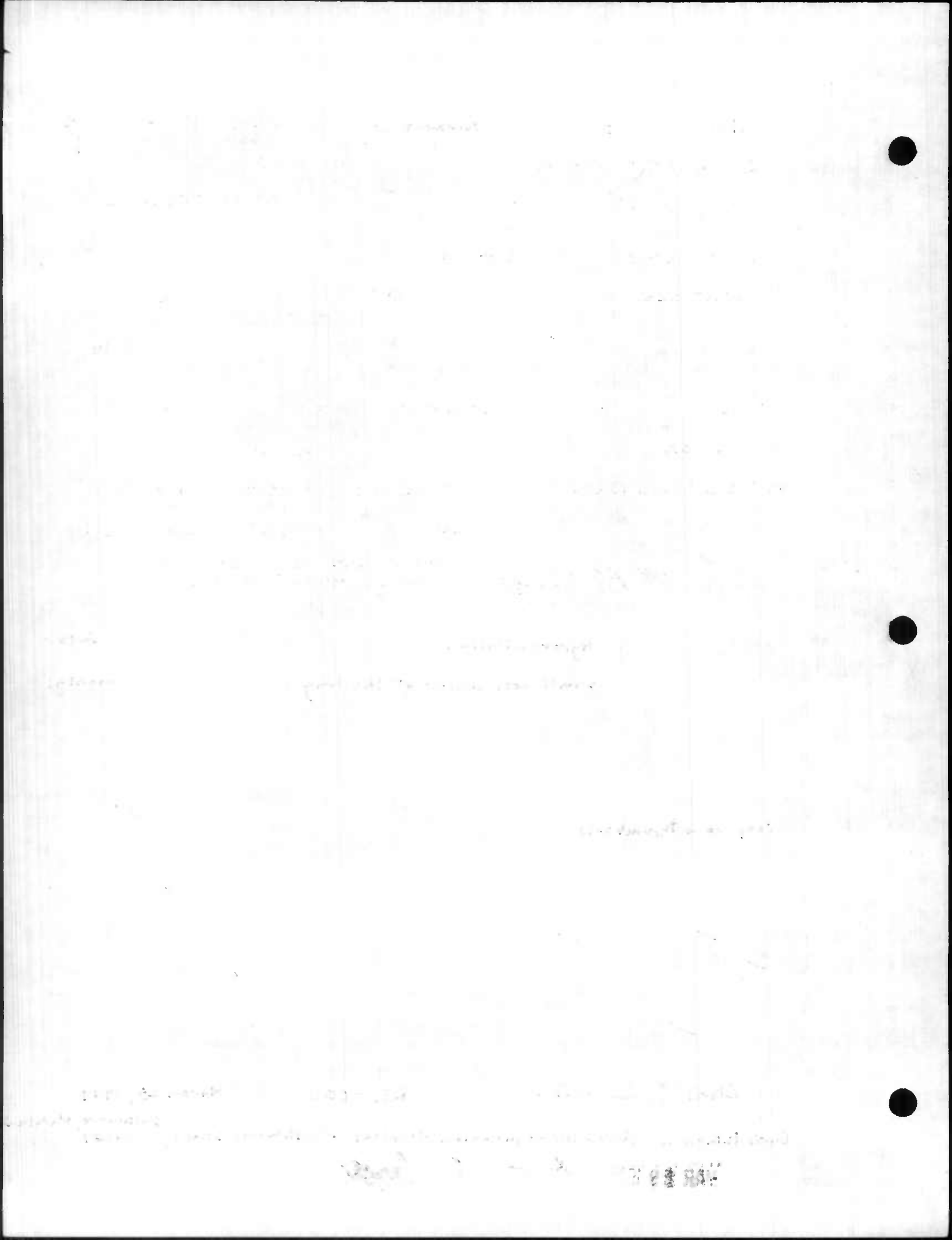
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12187

Certificate of Death

Reg. No.

|  |  |  |   |  |  |   |  |   |  |
|--|--|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>HARRY ALLAN RILEY</b>                       |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 27, 1999</b>  |   | 3. Time of Death<br><b>11:19 AM</b>  |   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>500 Richards Lane</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>Aberdeen</b>  |   | 4c. County of Death<br><b>Harford</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-05-0791</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 10, 1917</b>   |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                |  | 10. Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Bel Air</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |   |  |
| To Be Completed by Funeral Director                                  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Statistician</b>  |  |
|  |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>James Hanlon Riley, Sr.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Ellen Henderson</b>  |  | 19. Informant's Name/Relationship (Type, Print)<br><b>Marjorie Campbell - Sister</b>  |  |
| Physician<br>/Medical<br>Examiner                                    |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Johns Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Hydes, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Howard K. McComas</b>   |  |
|  |  | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>50 West Broadway, Bel Air, MD 21014</b>  |   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Renal Cell Carcinoma</b> |  | Approximate Interval Between Onset and Death<br><b>14 months</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No       |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
|  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| State Registrar  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>David S. Ettinger MD</b>   |  | 29c. License number<br><b>017207 MD</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>03/29/99</b>  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID S. ETTINGER MD, The Johns Hopkins Oncology Center Balto MD</b>  |   | 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |  | 32. Registrar's Signature<br><b>B. Spawth</b>   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12189

|   |  |   |  |  |   |  |                                |  |                                       |  |
|---|--|---|--|--|---|--|--------------------------------|--|---------------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Sandra Marie Ray</b>                                |   |  |  | 2. Date of Death<br>Month Day Year<br><b>March 23, 1999</b>   |  |                                |  | 3. Time of Death<br><b>7:20 am</b>    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b> |  |                                |  | 4c. County of Death<br><b>Harford</b> |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-50-2300</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.              |  | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.        |  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>May 20, 1948</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                    |  | Usual Residence of Decedent                                   |  |                                |  |                                       |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Havre de Grace</b>   |   |  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                       |  |
| 10e. Street and Number<br><b>665 Bourbon Street</b>   |  |   |  | 10f. Zip Code<br><b>21078</b>  |   |  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |                                       |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |                                       |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (1-4 or 5+) -----   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   |  |                                | 16b. Kind of Business/Industry<br><b>Own Home</b>  |                                       |  |
| 17. Father's Name (First, Middle, Last)<br><b>Stanley Diehl</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Mary Davidson</b>  |   |  |                                |  |                                       |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Deward Edward Ray (Son)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>108 Gracecroft Drive Havre de Grace, MD 21078</b>  |   |  |                                |  |                                       |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Angel Hill Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>3-26-99 Havre de Grace, MD</b>             |                                |  |                                       |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Mitchell-Smith Funeral Home P.A.<br/>123 S. Washington St. Havre de Grace, MD 21078</b>   |   |  |                                |  |                                       |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>BRAIN METASTASIS</b><br>Due to (or as a consequence of):<br><b>CANCER OF LUNG</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>LIVER METASTASIS</b><br>Due to (or as a consequence of): |  |   |  |  |   |  |                                | Approximate Interval Between Onset and Death   |                                       |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>LIVER METASTASIS</b>   |  |   |  |  |   |  |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                       |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |                                |  |                                       |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |                                |  |                                       |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                | 28d. Describe how injury occurred  |                                       |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D20215</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/23/99</b>                                |                                |  |                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K. S. NAIR M.D., 601- S. UNION AVE, HAVRE DE GRACE MD 21078</b>  |  |   |  |  |   |  |                                |  |                                       |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 25 1999</b>   |  | 32. Registrar's Signature<br>   |  |  |   |  |                                |  |                                       |  |







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12190

|  |  |  |   |   |  |  |   |  |  |
|--|--|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Madeline Robinette</b>   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>29</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>12:00pm</b>     |   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>236 East Elder Street</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b> |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-05-7528</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sep 23, 1913</b>  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>WV</b>  |  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Allegany</b>   |  | 10c. City, Town or Location<br><b>Cumberland</b>  |  |  |
| To Be Completed by Funeral Director                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>236 East Elder Street</b>  |   | 10f. Zip Code<br><b>21502</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retired Beautician</b>  |   | 16b. Kind of Business/Industry<br><b>Beauty Shop</b>   |  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Ritenour</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Myrtle V (Womax)</b>  |  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jerome Robinette son</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>511 Williams Street; Cumberland, MD 21502</b> |  |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>  |   | Date<br><b>4/01/</b>   |  | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home P.A. Cumberland, Maryland 21502</b>   |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Arteriosclerotic Heart Disease</b><br>Dua to (or as a consequence of):<br><br>b. <b>Diabetes</b><br>Dua to (or as a consequence of):<br><br>c.<br>Dua to (or as a consequence of):<br><br>d.<br>Dua to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |   |  |  |   | Approximate Interval Between Onset and Death<br><br><b>10 years</b><br><br><b>10 years</b>   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pulmonary Disease</b>   |  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|  |  |  | 28d. Describe how injury occurred   |   |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D09157</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1999</b>  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul Snow, M.D. 124 W. Third Street; Cumberland, MD 21502</b>   |  |   |   |  |  |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |  | 32. Registrar's Signature<br>  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|  |  |  |  |   |   |  |  |  |
|--|--|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>David Franklin Rodgers</b>                                  |  |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>27</b> Year <b>1999</b> |  | 3. Time of Death<br><b>13:46</b>                             |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>              |  | 4c. County of Death<br><b>WICOMICO</b>                       |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>292-24-5022</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><b>August 5, 1929</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Detroit, Michigan</b>                                       |  | 10. Usual Residence of Decedent  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Wicomico</b>                               |  |
| 10c. City, Town or Location<br><b>Salisbury</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>803 D College Lane</b>   |   | 10f. Zip Code<br><b>21804</b>  |  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>President</b>   |   | 16b. Kind of Business/Industry<br><b>Banking</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Rodgers</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Leona Morrison</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stephen E. Marohl, Sr./Son</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>129 Southdown Rd., Edgewater, MD 21037</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wicomico Memorial Park</b>   |   | 20c. Location - City or Town, State<br><b>Salisbury, MD</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>David H. Thompson</i> MO1051   |  |  |  | 22. Name and Address of Facility<br><b>Holloway Funeral Home, Professional Assoc.<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>  |   |  |  |  |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>PARAPNEUMONIC 2° Antic Dissection with T10 spinal</b><br><b>CORO INTRACTABLE 1995</b> |  |  |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 28d. Describe how injury occurred   |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><i>James L. Clifford MD</i>   |  |  |  | 29c. License number<br><b>D0001967</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>James L. Clifford 106 Pine Bluff Rd., Suite 12, Salisbury, MD 21801</b>   |  |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |  |  |  | 32. Registrar's Signature<br><i>Benita S. Sparks</i>  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

21

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12192

|   |  |   |  |   |  |   |  |                                   |
|---|--|---|--|---|--|---|--|-----------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EDWARD T. RILEY SR.</b>                             |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 26 1999</b> |   | 3. Time of Death<br><b>8:50 AM</b>   |                                   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ATLANTIC GENERAL HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BERLIN</b>      |   | 4c. County of Death<br><b>WORCESTER</b>  |                                   |
| Funeral<br>Director   | 5. Social Security Number<br><b>191-30-5517</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs.  | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 30, 1941</b>                                     |                                   |
|   | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>                                    |   |  |   |  |   |  |                                   |
| Usual Residence of Decedent   |  |   |  |   |  |   |  |                                   |
| 10a. State<br><b>DELAWARE</b>   |  | 10b. County<br><b>SUSSEX</b>  |  | 10c. City, Town or Location<br><b>SELBYVILLE</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                   |
| 10e. Street and Number<br><b>179 WEST POND CIRCLE, KEENWICK SOUND</b>   |  |   |  | 10f. Zip Code<br><b>19975</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |                                   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |                                   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>AUTO GLASS INSTALLER</b>  |  |   | 16b. Kind of Business/Industry<br><b>AUTOMOTIVE</b>  |                                   |
| 17. Father's Name (First, Middle, Last)<br><b>PHILIP RILEY</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VERA FRATENTONA</b>   |  |   |  |                                   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARYANN RILEY/WIFE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>179 WEST POND CIRCLE, SELBYVILLE, DELAWARE 19975</b>  |  |   |  |                                   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ROXANA CEMETERY</b>  |  | Date<br><b>3/31/99</b>  |  | 20c. Location - City or Town, State<br><b>ROXANA, DELAWARE</b>  |  |                                   |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>   |  |   |  |                                   |
| 23a. Pertinent: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>CORONARY OCCLUSION</b><br>Due to (or as a consequence of):<br><br>b. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |   |  |   |  |   |  |                                   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  |                                   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |                                   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           |  | 28d. Describe how injury occurred |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                          |  |                                   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |                                   |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D 06241</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>03-29-99</b>  |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DOROTHY C. HOLZNORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21863</b>   |  |   |  |   |  |   |  |                                   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |  |   |  | 32. Registrar's Signature<br>   |  |   |  |                                   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Time/Date 0850 3/26/99

Riley, Edward T  
DOB 5/30/41  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12193

Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |   |  |   |   |  |  |  |  |
|---|---|---|--|--|---|--|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Mary Elizabeth Robinson</u>                        |   |  |  | 2. Date of Death<br>Month <u>March</u> Day <u>30</u> Year <u>1999</u> |  | 3. Time of Death<br><u>9:30 A.M.</u>                        |  |   |   |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Mallard Bay Nursing Home</u> |   |  |  | 4b. City, Town, or Location of Death<br><u>Cambridge</u>              |  | 4c. County of Death<br><u>Dorchester</u>                    |  |   |   |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>213-14-6880</u>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>83</u> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>June 13, 1915</u> |  |   |   |  |  |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>                                       |   |  |  |   |  |   |  |   |   |  |  |  |  |
| Usual Residence of Decedent   |   |   |  |  |   |  |   |  |   |   |  |  |  |  |
| 10a. State<br><u>MD</u>   |   | 10b. County<br><u>Dorchester</u>  |  | 10c. City, Town or Location<br><u>Cambridge</u>  |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |  |  |
| 10e. Street and Number<br><u>701-Race Street Apt. 107</u>   |   |   |  | 10f. Zip Code<br><u>21613</u>  |   | 10g. Citizen of What Country?<br><u>USA</u>  |   |  |   |   |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>  |   |  |   |   |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>0</u> College (1-4or 5+) <u>0</u>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Seafood Picker</u>   |   | 16b. Kind of Business/Industry<br><u>SeaFood Industry</u>  |   |  |   |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>Richard Henry Johnson</u>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Julie Pritchett</u>  |   |  |   |  |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Lena Johns</u>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>P.O. Box 119 Hurlock, Maryland 21643</u>   |   |  |   |  |   |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Meekins Neck Cemetery</u>  |  | Date<br><u>8/05/99</u>   |   | 20c. Location - City or Town, State<br><u>Church Creek, MD.</u>  |   |  |   |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><u>Janelle C. Henry</u>  |   |   |  | 22. Name and Address of Facility<br><u>HENRY FUNERAL HOME P.A.<br/>510 Washington St Cambridge, MD. 21613</u>  |   |  |   |  |   |   |  |  |  |  |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |  |   |  |   |   |  |  |  |  |
| <table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last             </td> <td>a. <u>Urosepsis</u><br/>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><u>1 month</u></td> </tr> <tr> <td>b. <u>Abdominal Mass</u><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. <br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. <br/>Due to (or as a consequence of):</td> </tr> </table> |   |   |  |  |   |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <u>Urosepsis</u><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><u>1 month</u> | b. <u>Abdominal Mass</u><br>Due to (or as a consequence of): | c.<br>Due to (or as a consequence of): | d.<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a. <u>Urosepsis</u><br>Due to (or as a consequence of):   | Approximate Interval Between Onset and Death<br><u>1 month</u>  |  |  |   |  |   |  |   |   |  |  |  |  |
|   | b. <u>Abdominal Mass</u><br>Due to (or as a consequence of):                                      |   |  |  |   |  |   |  |   |   |  |  |  |  |
|   | c.<br>Due to (or as a consequence of):  |   |  |  |   |  |   |  |   |   |  |  |  |  |
|   | d.<br>Due to (or as a consequence of):  |   |  |  |   |  |   |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension</u><br><u>Degenerative Joint Disease</u>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><u>Mark E Velarde, MD</u>  |  | 29c. License number<br><u>D0053198</u>   |   | 29d. Date signed (Month, Day, Year)<br><u>MARCH 31, 1999</u>   |   |  |   |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>MARK E Velarde 503 BYRNST, Suite 1 Cambridge, MD 21613</u>   |   |   |  |  |   |  |   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 01 1999</u>   |   |   |  | 32. Registrar's Signature<br><u>Benita B. Sparks</u>   |   |  |   |  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020 toll  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar  
 DHMH 16 Rev 6/95





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12194

|  |   |   |  |  |  |  |  |  |  |                                   |  |
|--|---|---|--|--|--|--|--|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Waine Gordon Sterling                     |   |  |  |  |  | 2. Date of Death<br>Month Day Year<br>March 20, 1999       |  |  | 3. Time of Death<br>1:40 P.M.     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital |   |  |  |  |  | 4b. City, Town, or Location of Death<br>Silver Spring      |  |  | 4c. County of Death<br>Montgomery |  |
| Funeral<br>Director  | 5. Social Security Number<br>N/A  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>Yrs. Months Days |  | 8. Date of Birth (Month, Day, Year)<br>0 15 March 20, 1999 |  | 9. Birthplace (State or Foreign Country)<br>Maryland |                                   |  |
|  | Usual Residence of Decedent   |   |  |  |  |  |  |  |  |                                   |  |
| 10a. State<br>Maryland   |   | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Silver Spring   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                   |  |
| 10e. Street and Number<br>2842 Mozart Drive  |   |   |  | 10f. Zip Code<br>20904   |  | 10g. Citizen of What Country?<br>United States   |  |  |  |                                   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>N/A   |  |  |  | 16b. Kind of Business/Industry<br>N/A  |  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br>Gordon Waine Sterling   |   |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Victoria Elizabeth Harris   |  |  |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Gordon W. Sterling - Father  |   |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2842 Mozart Lane, Silver Spring, Maryland 20904 |  |  |  |                                   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Crematory  |  | Date<br>3-27-99  |  | 20c. Location - City or Town, State<br>Brentwood, Maryland   |  |                                   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |  |  |  | 22. Name and Address of Facility<br>Hines-Rinaldi Funeral Home, Inc.<br>11800 New Hampshire Ave., Silver Spring, Maryland 20904                  |  |  |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Severely prematurity - 22 wks gestation<br>Due to (or as a consequence of):<br>Pulmonary insufficiency<br>Due to (or as a consequence of):<br>prolonged rupture of membranes<br>Due to (or as a consequence of):<br>abruptio placenta<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |  |  |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>chorioamnionitis   |   |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |  |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |                                   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br>Mary Lenore Keszler, MD  |  | 29c. License number<br>D28060  |  | 29d. Date signed (Month, Day, Year)<br>3-22-99   |  |  |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MARY LENORE KESZLER, MD. HOLY CROSS HOSPITAL SILVER SPRING, MD.  |   |   |  |  |  |  |  |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 29 1999   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |  |  |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12195

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Joseph Salinger

2. Date of Death

Month Day Year  
March 25, 1999

3. Time of Death

6:35 AM

4a. Facility Name (If not institution, give street and number)

Bedford Court

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

094-24-0718

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 4, 1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3700 International Drive, #315

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Insurance Broker

16b. Kind of Business/Industry

Insurance Firm

17. Father's Name (First, Middle, Last)

Soloman Salinger

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Bijur

19a. Informant's Name/Relationship (Type, Print)

Peter A. Salinger (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5801 Ridgefield Road, Bethesda, MD 20816

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

3-26-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Salinger

22. Name and Address of Facility

Rapp Funeral Services, P.A.  
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cerebrovascular Accident

Approximate Interval Between Onset and Death

immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Organic Brain Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Arthur Schoengold

29c. License number

D18726

29d. Date signed (Month, Day, Year)

March 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur Schoengold, M.D., 18111 Prince Philip Drive, Olney, Maryland 20832

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12196

|   |   |   |  |  |   |  |  |  |
|---|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>JUNE G. SHEEHAN                                   |   |  |  | 2. Date of Death<br>Month Day Year<br>March 27 1999 |  | 3. Time of Death<br>9:45 pm  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center |   |  |  | 4b. City, Town, or Location of Death<br>Annapolis   |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director   | 5. Social Security Number<br>579-22-0546  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>75 Yrs.  | If Under 1 Year<br>Months Days                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>June 7, 1923  | 9. Birthplace (State or Foreign Country)<br>DC                           |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |  |
| 10a. State<br>MD  |   | 10b. County<br>Queen Annes  |  | 10c. City, Town or Location<br>Stevensville  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>405 Butler Landing Drive  |   |   |  | 10f. Zip Code<br>21666   |   | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Department Director   |   |  | 16b. Kind of Business/Industry<br>HUD  |  |
| 17. Father's Name (First, Middle, Last)<br>Gerald Kevin Mulvey  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Adele Adelaide Norton   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Kristie S. Key / Daughter   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>405 Butler Landing Drive, Stevensville, MD 21666  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |  | Date<br>3/30/99  |   | 20c. Location - City or Town, State<br>Silver Spring, MD   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Mark Pikel</i>  |   |   |  | 22. Name and Address of Facility<br>Collins Funeral Home<br>500 University Blvd, W. Silver Spring, MD 20901  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. MYOCARDIAL INFARCTION / ASCVD<br>Due to (or as a consequence of):<br>b. VENTRICULAR FIBRILLATION<br>Due to (or as a consequence of):<br>c. ASCVD<br>Due to (or as a consequence of):<br>d. PNEUMONIA<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br>30 min<br>1 Day<br>1 Day |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ATRIAL FIBRILLATION<br>Cerebral Vascular Accident<br>PNEUMONIA  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><i>Christopher G. Sparks MD</i>  |  | 29c. License number  |   | 29d. Date signed (Month, Day, Year)<br>3/27/99   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>POB 4826 Baltimore MD 21211   |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 29 1999  |   | 32. Registrar's Signature<br><i>Genevieve B. Sparks</i>   |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene 99-12197

Certificate of Death

Reg. No.

|  |   |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|--|---|--|---|---|--|--|--|--|---|-----------------|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>LEE YIN LIN SHUEH   |  |   |   | 2. Date of Death<br>Month Day Year<br>MARCH 23 1999  |  | 3. Time of Death<br>1:50 AM                                      |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>1501 VIVIAN PLACE   |  |   |   | 4b. City, Town, or Location of Death<br>SILVER SPRING  |  | 4c. County of Death<br>MONTGOMERY                                |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>226-92-3072  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>61 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>JUNE 23, 1937             | 9. Birthplace (State or Foreign Country)<br>MALAYSIA |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | Usual Residence of Decedent   |  |   |   | 10a. State<br>MARYLAND   |  | 10b. County<br>MONTGOMERY  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br>SILVER SPRING  |  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | 10e. Street and Number<br>1501 VIVIAN PLACE   |  |   |   | 10f. Zip Code<br>20902   |  | 10g. Citizen of What Country?<br>UNITED STATES                   |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: ASIAN |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5 College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER   |  | 16b. Kind of Business/Industry<br>OWN HOME                       |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>CHOON LEE  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>YUT HO CHOW   |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>SHIH-AN SHUEH/ HUSBAND  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1501 VIVIAN PLACE, SILVER SPRING, MD. 20902   |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>FORT LINCOLN CREMATORY  |   | Date<br>3/25/99  |  | 20c. Location - City or Town, State<br>BRENTWOOD, MARYLAND       |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>▶ Alan Daniel  |  |   |   | 22. Name and Address of Facility<br>HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD. 20904  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="7">a. COLON CANCER</td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td colspan="7">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">d. Due to (or as a consequence of):</td> </tr> </table> |  |   |   |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. COLON CANCER |  |  |  |  |  |  | Due to (or as a consequence of): |  |  |  |  |  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): |  |  |  |  |  |  | c. Due to (or as a consequence of): |  |  |  |  |  |  | d. Due to (or as a consequence of): |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  | a. COLON CANCER   |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | Due to (or as a consequence of):  |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | b. Due to (or as a consequence of):    |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
|  |   | c. Due to (or as a consequence of):    |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| d. Due to (or as a consequence of):  |   |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 28d. Describe how injury occurred  |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 29b. Signature and title of certifier<br>▶ [Signature]   |   |  |   | 29c. License number<br>D 29675  |  | 29d. Date signed (Month, Day, Year)<br>MARCH 24, 1999                                |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>RALPH V. BOCCIA, M.D. 10605 CONCORD ST. #300 KENSINGTON, MD 20895  |   |  |   |   |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 29 1999   |   |  |   | 32. Registrar's Signature<br>[Signature]  |  |  |  |  |   |                 |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12198

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SEDELL SILVERMAN

2. Date of Death

March 30 1999

3. Time of Death

0145

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

BROOKGROVE NURSING HOME

4b. City, Town, or Location of Death

SANDY SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

194.30.6835

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01.22.1906

9. Birthplace (State or Foreign Country)

IRELAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SANDY SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18430 BROOKEGROVE ROAD

10f. Zip Code

20860

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

"UNKNOWN"

18. Mother's Name (First, Middle, Maiden Surname)

BLOOMA ZEIDER

19a. Informant's Name/Relationship (Type, Print)

CAROLE FORMAN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4649 CHAPEL HILL DR, UNIT 2825, SARASOTA, FL 34238

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MT. COMFORT CREMATORY

Date

4.2.99

20c. Location - City or Town, State

ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

PNEUMONIA

Due to (or as a consequence of):

ALZHEIMER'S DISEASE

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HIP FRACTURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

FEBRUARY 22, 1999

28b. Time of  
Injury

1000 M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SLIPFALL ON FLOOR

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

ASSISTED LIVING CENTER -

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)15903 MARLBOROUGH CT  
ROCKVILLE, MD29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD (OMB)

29c. License number

015236

29d. Date signed (Month, Day, Year)

MARCH 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CARL I. MARGOLIS, M.D. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12199

|  |   |   |  |  |   |  |  |  |
|--|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>STEVEN MATTHEW SIMMONS</b>                         |   |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 24, 1999</b> |  | 3. Time of Death<br><b>1742 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>LAUREL REGIONAL HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>LAUREL</b>       |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-02-0817</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>33</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 13, 1965</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |
|  | Usual Residence of Decedent   |   |  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>BURTONSVILLE</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>4201 FALCONWOOD PLACE</b>   |   |   |  | 10f. Zip Code<br><b>20866</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>               |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FILE AND DATA CLERK</b>  |   |  | 16b. Kind of Business/Industry<br><b>DEPT. OF AGRICULTURE</b>                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ROBERT WINFIELD SIMMONS, SR.</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LILLIAN MAY</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT W. SIMMONS, SR./FATHER</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4201 FALCONWOOD PL. BURTONSVILLE, MD 20866</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>UNION CEMETERY</b>  |   | Date<br><b>3/29/99</b>                                       |  | 20c. Location - City or Town, State<br><b>BURTONSVILLE, MD</b>   |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>HINES-RINALDI FUNERAL HOME, INC.<br/>11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904</b>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Ischemic heart disease</b>   |   |   |  |  |   |  |  |  |
| Due to (or as a consequence of):<br><b>Aortic Root Dissection</b>  |   |   |  |  |   |  |  |  |
| Due to (or as a consequence of):   |   |   |  |  |   |  |  |  |
| Due to (or as a consequence of):   |   |   |  |  |   |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |   |   |  |  |   |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|  |   |   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   |   |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |   |  | 28d. Describe how injury occurred  |   |  |  |  |
|  |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |  |
|  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>O.C.M.E</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 25, 1999</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>  |   |   |  | 32. Registrar's Signature<br>  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12200

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) CLARA PEARL SMITH

2. Date of Death Month Day Year MARCH 29, 1999

3. Time of Death 1:48 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number) 1714 MERRIMAC DRIVE

4b. City, Town, or Location of Death ADELPHI

4c. County of Death PRINCE GEORGES

5. Social Security Number 416-32-6464

6. Sex ☐ M ☒ F

7. Age (In yrs. last birthday) 71 Yrs.

8. Date of Birth (Month, Day, Year) OCT. 17, 1927

9. Birthplace (State or Foreign Country) GEORGIA

Usual Residence of Decedent

10a. State MD

10b. County PRINCE GEORGES

10c. City, Town or Location ADELPHI

10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number 1714 MERRIMAC DRIVE

10f. Zip Code 20783

10g. Citizen of What Country? U.S.A.

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HEALTHCARE PROFESSIONAL

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last) BEN MARCUS

18. Mother's Name (First, Middle, Maiden Surname) FANNIEMAE BAILEY

19a. Informant's Name/Relationship (Type, Print) VELLETTA SMITH JACKSON/DAU.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 MERRIMAC DRIVE ADELPHI, MD 20783

20a. Method of Disposition ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) NEUNAN, GEORGIA

20c. Location - City or Town, State NEUNAN, GEORGIA

20d. Date 4/3/99

21. Signature of Funeral Service Licensee

22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLOROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Coronary Disease

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No

26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 3/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HECTOR K. COLLISON, M.D. 8404 COLESVILLE RD. SILVER SPRING, MD. 20910

State  
Registrar

31. Date filed (Month, Day, Year) APR 02 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12201

|  |   |   |   |  |  |  |  |  |   |  |
|--|---|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Jean Willson Spielman</u>                      |   |   |  |  | 2. Date of Death<br>Month Day Year<br><u>March 31, 1999</u>                          |  | 3. Time of Death<br><u>12:28 AM</u>  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>4304 Chestnut Street</u> |   |   |  |  | 4b. City, Town, or Location of Death<br><u>Bethesda</u>                              |  | 4c. County of Death<br><u>Montgomery</u>   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>213-40-7653</u>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>81</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>Nov. 30, 1917</u>  |  | 9. Birthplace (State or Foreign Country)<br><u>Canada</u> |  |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |  |   |  |
| 10a. State<br><u>Maryland</u>  |   | 10b. County<br><u>Montgomery</u>  |   | 10c. City, Town or Location<br><u>Bethesda</u> |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><u>4304 Chestnut Street</u>  |   |   |   |  | 10f. Zip Code<br><u>20814</u>  |  | 10g. Citizen of What Country?<br><u>United States</u>  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                            |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>-</u>   |   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Secretary</u>  |  |  | 16b. Kind of Business/Industry<br><u>Montgomery County Public Schools</u>                          |   |  |
| 17. Father's Name (First, Middle, Last)<br><u>John Archibald Willson</u>   |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Jessie Mathieson</u>   |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Diane S. Rexroad/Daughter</u>   |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>4304 Chestnut Street, Bethesda, MD 20814</u>   |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Montgomery Crematorium, Inc.</u>   |  |  | 20c. Location - City or Town, State<br><u>Bethesda, Maryland</u>                     |  | 20d. Date<br><u>April 1, 1999</u>  |   |  |
| 21. Signature of Funeral Service Representative<br><u>[Signature]</u> <u>400689</u>  |   |   |   |  | 22. Name and Address of Facility<br><u>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</u>                                      |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <u>respiratory failure</u><br>Due to (or as a consequence of):<br><br>b. <u>myocardial infarction</u><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |   |  |  |  |  |  |   |  |
| Approximate Interval Between Onset and Death<br><br>e. <u>1 week</u><br><br>b. <u>1 week</u><br><br>c.<br><br>d.<br>   |   |   |   |  |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>myeloproliferative disorder</u>   |   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><u>M</u>                |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |   |  |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>  |   |   |   |  | 29c. License number<br><u>D43083</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>March 31, 1999</u>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>George A. Sotos, M.D., 10605 Concord Street, #300, Kensington, Maryland 20895-2594</u>  |   |   |   |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 02 1999</u>  |   |   |   |  | 32. Registrar's Signature<br><u>[Signature]</u>  |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12202

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Walter Staines</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 27, 1999</b>   |  |  |  | 3. Time of Death<br><b>9:30 am</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>12301 St. James Road</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Potomac</b>  |  |  |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| 5. Social Security Number<br><b>213-42-6211</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>June 25, 1927</b>                    |  | 9. Birthplace (State or Foreign Country)<br><b>Australia</b>  |  |
| Usual Residence of Decedent  |  |   |  |   |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Potomac</b>   |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>12301 St. James Road</b>  |  |   |  | 10f. Zip Code<br><b>20854</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                          |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Draftsman</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Architecture</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Walter Staines</b>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy A. Shepard</b> |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Hazel Staines Bray/ Ex-wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1160 Redbud Lane Moneta, Virginia 24121</b>   |  |  |  |   |  |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |  |  |  | 20c. Location - City or Town, State<br><b>Rockville, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M00335</b>   |  |   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Rockville, Inc.<br/>300 West Montgomery Avenue Rockville, Maryland 20850</b>  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Bladder Cancer</b>  |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>a. Due to (or as a consequence of):   |  |   |  |   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):  |  |   |  |   |  |  |  |   |  |
| c. Due to (or as a consequence of):  |  |   |  |   |  |  |  |   |  |
| d. Due to (or as a consequence of):  |  |   |  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  |   |  |   |  |  |  | 24b. Were autopsy findings evaluable prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  |   |  | 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
|  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>50445</b>   |  |
|  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1999</b>  |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kenneth Kotz, M.D. 3020 Hamaker Court Fairfax, Virginia 22031</b>   |  |   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |   |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12203

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ella Stern

2. Date of Death

Month Day Year  
Apr 1 1999

3. Time of Death

2:20 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

130-05-1072

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
October 24 1916

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6000 California Circle

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Solomon Lustman

18. Mother's Name (First, Middle, Maiden Surname)

Lea Gutfreund

19a. Informant's Name/Relationship (Type, Print)

Melvin Stern/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7609 Rossdhu Court, Chevy Chase, MD 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory, or other place)

Eretz Ha Chaim

Cemetery

Date

4/7/99 Bet Shemesh, Israel

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Reginald H.

22. Name and Address of Facility

Takoma Funeral Home  
254 Carroll St., Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRATEPATIC HEMORRHAGE

Due to (or as a consequence of):

b. CHRONIC ANTICOAGULATION

Due to (or as a consequence of):

c. ACUTE RENAL FAILURE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 DAY

2 DAY

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBRAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alon Diamond

29c. License number

D 24245

29d. Date signed (Month, Day, Year)

4/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN DIAMOND, MD, 10801 CORKWOOD DR., SILVER SPRING, MD

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 303-593-5000.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



jhm  
KAREN  
SULLIVAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12204

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>KAREN E. SULLIVAN</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 28, 1999</b>  |  | 3. Time of Death<br><b>02:02 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ANNE ARUNDAL HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>   |  | 4c. County of Death<br><b>ANNE ARUNDAL</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-66-9963</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 11, 1953</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>WASH. D.C.</b>  |  |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD.</b>  | 10b. County<br><b>PRINCE GEORGES</b>  | 10c. City, Town or Location<br><b>BELTSVILLE</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br><b>13011 ELKRIDGE ST.</b>   |   |   | 10f. Zip Code<br><b>20705</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                     |  | 16b. Kind of Business/Industry<br><b>AT HOME</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>WAYNE LESLIE</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ALYCE M. SHELTON</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>LE ANNE BLAKE/SISTER</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6504 WESTERN AVE., CHEVY CHASE, MD. 20815</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>  |  | Date<br><b>4/2/99</b>  |  | 20c. Location - City or Town, State<br><b>SILVER SPRING, MD.</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br> MO0091  |   |   |  | 22. Name and Address of Facility<br><b>CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Peritonitis</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |  |  | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |  |
| 28d. Describe how injury occurred   |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |   |   | 29c. License number<br><b>OCME</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 30, 1999</b>                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. L. Sparks, MD</b>   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>   |   | 32. Registrar's Signature<br> <b>111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12205

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Lynwood Joseph Sterling, Jr.</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>April 5 1999</b>   |  | 3. Time of Death<br><b>5:00 a.m.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Mary's Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>  |  | 4c. County of Death<br><b>St. Mary's</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>220-07-0557</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>November 13, 1921</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>Leonardtown</b>   |  |
| To Be Completed by Funeral Director           | 10d. inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>P.O. Box 124, Washington Street</b>  |  | 10f. Zip Code<br><b>20650</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>         |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Construction</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Lynwood Joseph Sterling, Sr.</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Elizabeth Camalier</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Walter Kirk Sterling/Brother</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 203, Leonardtown, Maryland 20650</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Aloysius Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Leonardtown, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Michael H. Ford</i>   |  |  |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pneumonia</b>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |
|   | 23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Days</b>  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)<br><b>4-5-99</b>  |  |  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 28d. Describe how injury occurred<br><b>...</b>   |  |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>...</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br><i>William Boyd</i>  |  |   |  |
|   | 29c. License number<br><b>D14285</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>4-5-99</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (item 23e) (Type, Print)<br><b>WILLIAM BOYD, MD. P.O. BOX 1753 LEONARDTOWN, MD 20650</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 7 1999</b>  |  |   |  |
|   | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |  | 33. Registrar's Title<br><b>...</b>   |  |   |  |







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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12206

|  |   |                           |   |   |  |   |   |  |  |  |
|--|---|---------------------------|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Mary Ann Smith                                |                           |   |   | 2. Date of Death<br>Month Day Year<br>March 23, 1999   |   |   |  | 3. Time of Death<br>10:30 AM                               |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>21535 South Essex Drive |                           |   |   | 4b. City, Town, or Location of Death<br>Lexington Park   |   |   |  | 4c. County of Death<br>St. Mary's                          |  |
| Funeral<br>Director  | 5. Social Security Number<br>579-64-5194  |                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>54 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>April 15, 1944 |  | 9. Birthplace (State or Foreign Country)<br>North Carolina |  |
|  | Usual Residence of Decedent   |                           |   |   |  |   |   |  |  |  |
| 10a. State<br>Maryland   |   | 10b. County<br>St. Mary's |   | 10c. City, Town or Location<br>Lexington Park   |  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>21535 South Essex Drive  |   |                           |   | 10f. Zip Code<br>20653  |  |   |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11th College (1-4or 5+) 11th  |   |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Salesman   |  |   |   | 16b. Kind of Business/Industry<br>Retail   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Richard Smith   |   |                           |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Inez McCoy |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Patricia Smith/Sister  |   |                           |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>21535 South Essex Drive, Lexington Park, MD 20653  |  |   |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sunrise Cemetery  |  | Date<br>3/29/99   |   | 20c. Location - City or Town, State<br>Smithfield, NC  |  |  |
| 21. Signature of Funeral Service Licensee<br>Michael S. Gardiner   |   |                           |   | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, MD 20650   |  |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Congestive Heart Failure<br>Due to (or as a consequence of):<br>Hypertension<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                           |   |   |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |                           |   |   |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                           |   |   |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |                           |   |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Tobacco Addiction  |   |                           |   |   |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                           |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |                           |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                           |   | 28d. Describe how Injury occurred   |  |   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                           |   |   |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                           |   |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>Michael S. Szkotnicki, MD   |   |                           |   | 29c. License number<br>D31952MO   |  |   |   | 29d. Date signed (Month, Day, Year)<br>3/23/99   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Michael S. Szkotnicki, MD California, MD 20619   |   |                           |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 7 1999  |   |                           |   | 32. Registrar's Signature<br>Benita B. Sparks   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |  |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|---|--|---|---|--|---|--|--|--|---|---|--|--|----|--|--|--|--|-----------------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Harold Alonza Samuels, Jr.   |   |   |  | 2. Date of Death<br>Month Day Year<br>April 6 1999  |  | 3. Time of Death<br>5:10 PM                                      |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>St. Mary's Hospital  |   |   |  | 4b. City, Town, or Location of Death<br>Leonardtown   |  | 4c. County of Death<br>St. Mary's                                |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>226-72-5303   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>48 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>March 24, 1951            |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Virginia   |   | 10a. State<br>Maryland  |  | 10b. County<br>St. Mary's   |  | 10c. City, Town or Location<br>Loveville                         |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | 10e. Street and Number<br>28410 Point Lookout Road   |   |   |  | 10f. Zip Code<br>20656  |  | 10g. Citizen of What Country?<br>United States                   |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9   |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Repossession                              |  | 16b. Kind of Business/Industry<br>Automobile  |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Harold A. Samuel, Sr.   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Thelma Eanes   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Sharon Irene Samuels, Wife   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>28410 Point Lookout Road, Loveville, MD 20656  |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory  |  | Date<br>4-7-99  |  | 20c. Location - City or Town, State<br>Alexandria, Virginia      |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Ronald L. Thompson, Jr. MO01154   |   |   |  | 22. Name and Address of Facility<br>Brinsfield Funeral Home, P.A.<br>22955 Hollywood Road, Leonardtown, MD 20650  |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Acute Respiratory Failure</u></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/>3 days</td> </tr> <tr> <td>b. <u>Acute exacerbation of COPD</u></td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table> |   |   |  |   |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <u>Acute Respiratory Failure</u>   | Approximate Interval Between Onset and Death<br>3 days   | b. <u>Acute exacerbation of COPD</u>   | c. | d.   |  |  |  |                                   |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   | a. <u>Acute Respiratory Failure</u>  | Approximate Interval Between Onset and Death<br>3 days  |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | b. <u>Acute exacerbation of COPD</u>   |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | c.   |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
|   | d.   |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
| <table border="1"> <tr> <td colspan="2">23b. Did tobacco use contribute to the cause of death?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td>24a. Was an autopsy performed?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> </table>   |  |   |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |    |  |  |  |  |                                   |  |  |  |  |  |
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| <table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">26. Place of Death (Check only one)<br/>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death<br/>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br/>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28. Time of Injury<br/>28a. Date of Injury (Month, Day Year)<br/>28b. Time of Injury<br/>M<br/>28c. Injury at Work?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="2">28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> <td colspan="2"></td> </tr> </table> |  |   |   |  |   |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |    | 28. Time of Injury<br>28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28d. Describe how injury occurred |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
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| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
| <table border="1"> <tr> <td colspan="2">29a. Certifier (Check only one)<br/>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</td> </tr> <tr> <td>29b. Signature and title of certifier<br/><u>Kiran Mehta</u></td> <td>29c. License number<br/>D 36206</td> </tr> <tr> <td colspan="2">29d. Date signed (Month, Day, Year)<br/>4/7/99</td> </tr> </table>   |  |   |   |  |   |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><u>Kiran Mehta</u>   | 29c. License number<br>D 36206   | 29d. Date signed (Month, Day, Year)<br>4/7/99  |    |  |  |  |  |                                   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><u>Kiran Mehta</u>   | 29c. License number<br>D 36206   |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br>4/7/99   |  |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>KIRAN MEHTA M.D. PHILIP J. BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636   |  |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 09 1999  |  |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |
| 32. Registrar's Signature<br><u>B. Sparks</u>   |  |   |   |  |   |  |  |  |   |   |  |  |    |  |  |  |  |                                   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

HAROLD ALONZA SAMUELS

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



WRC

99-1867-025

JAMES H.

STULLER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 26 PER MEO G771 5-14-99 WR

## Certificate of Death

Reg. No.

99 12208

|   |   |   |  |   |   |   |  |  |  |
|---|---|---|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES H. STULLER</b>                                 |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 30, 1999</b> |   | 3. Time of Death<br><b>6:22 PM.</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1310 SHERIDAN PL. APT. 303</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BELAIR</b>       |   | 4c. County of Death<br><b>Harford</b>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-76-7693</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>4/8/58</b>        |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | Usual Residence of Decedent   |   |  |   |   |   |  |  |  |
| 10a. State<br><b>PA</b>   |   | 10b. County<br><b>York</b>  |  | 10c. City, Town or Location<br><b>Delta</b>   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>711 Main Street</b>  |   |   |  | 10f. Zip Code<br><b>17314</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>       |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>College (14 or 5+)</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mason</b>   |   |   | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Stuller</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Yvonne Hall</b>   |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Brenda J. Stuller/Wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21015 1310 Sheridan Place, Apt. 303, Bel Air, MD</b>   |   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Nebo Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>4/3 Delta, PA</b> |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Harkins Funeral Home, Inc., Delta, PA</b>  |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>DIABETIC KETOACIDOSIS</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |   |   |   |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |   |   |  |   |   |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   |   |   |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>WIFE RESIDENCE</b> |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |   |   |  | 28d. Describe how injury occurred   |   |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  | 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>O.C.M.E.</b>   |  |
|   |   |   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 31, 1999</b>  |   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 5 1999</b>  |   |   |  | 32. Registrar's Signature<br>   |   |   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12209

Certificate of Death

Reg. No.

|  |   |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
|--|---|--|--|---|--|---|--|--|---|---|----|-----------|------|----------------------------------|--|--|----|-----------|--------|----------------------------------|--|--|----|-------------------|-------|----------------------------------|--|--|----|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>George Lewis Seielstad                                    |  |  |   | 2. Date of Death<br>Month Day Year<br>March 29 1999  |   |  |  | 3. Time of Death<br>5:10 pm                           |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Genesis Elder Care, Knollwood Manor |  |  |   | 4b. City, Town, or Location of Death<br>Millersville |   |  |  | 4c. County of Death<br>Anne Arundel                   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>383-10-5100  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>86 Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br>June 27, 1912 |  | 9. Birthplace (State or Foreign Country)<br>Tennessee |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
|  | Usual Residence of Decedent   |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 10a. State<br>Maryland   |   | 10b. County<br>Anne Arundel  |  | 10c. City, Town or Location<br>Millersville   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 10e. Street and Number<br>899 Cecil Avenue   |   |  |  | 10f. Zip Code<br>21108  |  |   |  | 10g. Citizen of What Country?<br>United States   |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1942 to 1946 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                               |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Writer   |  |   |  | 16b. Kind of Business/Industry<br>Applied Physics  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br>Julius Seielstad  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bertha Munn  |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Virginia Dove (daughter)   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rt. 3 Box 123, Appleton City, Missouri 64729   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Crematory  |  | Date<br>4/2/99  |  | 20c. Location - City or Town, State<br>Brentwood, Maryland                                  |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 21. Signature of Funeral Director<br>  |   |  |  | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc.<br>47 Duke of Gloucester St. Annapolis, MD 21401  |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| <table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td>pneumonia</td> <td>days</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>dysphagia</td> <td>months</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>advanced dementia</td> <td>years</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |   |  |  |   |  |   |  |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | pneumonia | days | Due to (or as a consequence of): |  |  | b. | dysphagia | months | Due to (or as a consequence of): |  |  | c. | advanced dementia | years | Due to (or as a consequence of): |  |  | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.  | pneumonia  | days   |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
|  | Due to (or as a consequence of):  |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
|  | b.  | dysphagia  | months   |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
|  | Due to (or as a consequence of):  |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| c.   | advanced dementia   | years  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| Due to (or as a consequence of):   |   |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| d.   |   |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| right and left hip decubitus ulcers<br>prostatic hypertrophy with recurrent<br>urinary tract infections  |   |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 29b. Signature and title of certifier<br>  |   |  |  | 29c. License number<br>D41955   |  |   |  | 29d. Date signed (Month, Day, Year)<br>3-30-99   |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Rebecca Elon, MD, 1454 B & A Blvd. Arnold, MD 21012  |   |  |  |   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999   |   |  |  | 32. Registrar's Signature<br>   |  |   |  |  |   |   |    |           |      |                                  |  |  |    |           |        |                                  |  |  |    |                   |       |                                  |  |  |    |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12210

|  |  |  |  |   |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Paul Schou</i>  |  |  |   | 2. Date of Death<br>Month <i>3</i> Day <i>30</i> Year <i>99</i> |  | 3. Time of Death<br><i>07:10</i>                            |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Anne Arundel Medical Center</i> |  |  |   | 4b. City, Town, or Location of Death<br><i>Annapolis</i>        |  | 4c. County of Death<br><i>Anne Arundel</i>                  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>029-24-3224</i>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><i>66</i> Yrs.                |  | 8. Date of Birth (Month, Day, Year)<br><i>June 28, 1932</i> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><i>Massachusetts</i>                                     |  | 10a. State<br><i>Maryland</i>  |   | 10b. County<br><i>Anne Arundel</i>                              |  | 10c. City, Town or Location<br><i>Annapolis</i>             |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><i>501 Tayman Drive</i>   |   | 10f. Zip Code<br><i>21403</i>  |   | 10g. Citizen of What Country?<br><i>USA</i>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>4</i> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Engineer</i>                       |  | 16b. Kind of Business/Industry<br><i>Aerospace</i>  |   | 17. Father's Name (First, Middle, Last)<br><i>Berthel B. Schou</i>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Ruth Larsen</i>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Sue A. Schou/ Wife</i>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>501 Tayman Drive Annapolis, Maryland 21403</i> |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Lakemont Mem'l. Gardens</i>   |   | 20c. Location - City or Town, State<br><i>4-2-99 Davidsonville, MD</i>   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><i>George P. Kalas Funeral Home</i><br><i>2973 Solomons Island Rd. Edgewater, MD 21037</i>                     |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Amyotrophic lateral sclerosis</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>b. Due to (or as a consequence of):</i><br><i>c. Due to (or as a consequence of):</i><br><i>d. Due to (or as a consequence of):</i> |   | Approximate Interval Between Onset and Death<br><i>12 years</i>  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |  |
|  |  |  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                        |  | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)   |  |
|  |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |   | 29c. License number<br><i>05181</i>  |  |
|  |  | 29d. Date signed (Month, Day, Year)<br><i>3/30/99</i>  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Matthew Malta, M.D.</i><br><i>1833-A Forest Drive, Annapolis MD 21401</i>  |   | 31. Date filed (Month, Day, Year)<br><i>APR 01 1999</i>  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12211**  
**Certificate of Death**

Reg. No.

|  |  |   |  |  |   |  |  |   |
|--|--|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Lillian M. Smith</b>                                  |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>29</b> Year <b>1999</b> |  | 3. Time of Death<br><b>9:35 am</b>   |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Anne Arundel Medical Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>              |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-28-8914</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 28, 1917</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|  | Usual Residence of Decedent  |   |  |  |   |  |  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Annapolis</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>130 Hearne Road, #705</b>   |  |   |  | 10f. Zip Code<br><b>21401</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Grafton Mills</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Daisy Trott</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James E. Smith (Son)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3057 Centre Road, Riva, MD 21140</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hillcrest</b>   |   | Date<br><b>03/31</b>   |  | 20c. Location - City or Town, State<br><b>Annapolis, MD</b> |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Avenue, Annapolis, MD 21401</b>  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Congestive heart failure</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>chronic renal failure, Urinary tract infection, Type II diabetes,</b>   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred                           |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>241816</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charles W. Phelps MD, Anne Arundel Medical Center</b>   |  |   |  |  |   |  |  | <b>64 Franklin St.<br/>Annapolis, MD 21041</b>              |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |  | 32. Registrar's Signature<br>   |  |  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified in advance.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2021 0 2 0AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12212**  
**Certificate of Death**

Reg. No.

|  |  |  |   |                                      |   |   |  |  |
|--|--|--|---|--------------------------------------|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ELSIE P. SIMMS</b>  |  |   |                                      | 2. Date of Death<br>Month Day Year<br><b>MARCH 23 1999</b>  |   | 3. Time of Death<br><b>1:33 am</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1111 WATERFORD DRIVE</b>  |  |   |                                      | 4b. City, Town, or Location of Death<br><b>DISTRICT HEIGHTS PRINCE GEORGE</b>   |   | 4c. County of Death  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-30-4695</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 24 1903 MARYLAND</b>   |  |
|  | 9. Birthplace (State or Foreign Country)   |  | 10a. State<br><b>MARYLAND</b>   |                                      | 10b. County<br><b>PRINCE GEORGE</b>   |   | 10c. City, Town or Location<br><b>DISTRICT HEIGHTS</b>   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  |   |                                      | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
|  | 10e. Street and Number<br><b>1111 WATERFORD DRIVE</b>  |  |   |                                      | 10f. Zip Code<br><b>20747</b>   |   | 10g. Citizen of What Country?<br><b>US</b>   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DOMESTIC</b>                          |                                      | 16b. Kind of Business/Industry<br><b>OUT OF THE HOME</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>CHARLES PARKER</b>   |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MATILDA HOPKINS</b>   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>SHIRLEY M. JACKS (DAUGHTER)</b>   |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1111 WATERFORD DR. DISTRICT HEIGHTS, MD. 20747</b>  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MOSES CEMETERY</b>   |                                      | 20c. Location - City or Town, State<br><b>3/27/99 DRURY, MARYLAND</b>   |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Harry D. Reese</b>   |  |   |                                      | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Anoxic Encephalopathy</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Severe Brachycardia</b><br/>Due to (or as a consequence of):</p> <p>c. <b>High degree Heart Block</b><br/>Due to (or as a consequence of):</p> <p>d. <b>Atherosclerotic Heart Disease</b></p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>a. <b>3 days</b></p> <p>b. <b>3 days</b></p> <p>c. <b>3-4 days</b></p> <p>d. <b>3-10 yrs</b></p> </div> </div> |  |   |                                      |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                      |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |  |   |                                      |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |  |  |
|  |  |  |   |                                      |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |                                      |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>      |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred    |   |   |  |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                                      |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |                                      |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Harry D. Reese</b>   |  |  |   | 29c. License number<br><b>D33483</b> |   | 29d. Date signed (Month, Day, Year)<br><b>3/26/99</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TRADEP SRIWASITAWAT, 7227-B Hanover Phung (with ID) 20770</b>   |  |  |   |                                      |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |  | 32. Registrar's Signature<br><b>James B. Spence</b>  |   |                                      |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

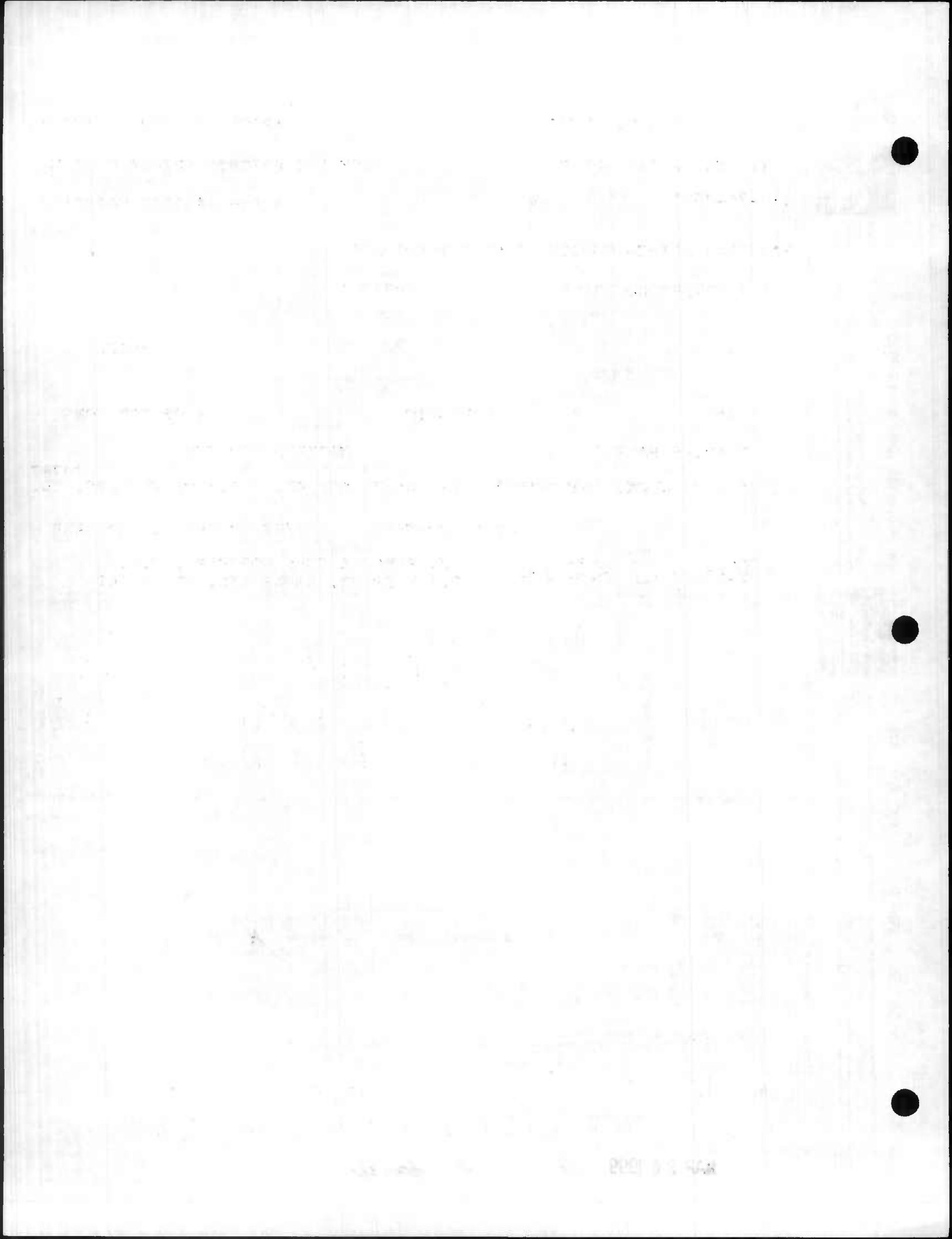
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12213

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |  |                                |  |   |
|---|--|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Regina Spiker</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>25</b> Year <b>1999</b>  |                                | 3. Time of Death<br><b>1825</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |                                | 4c. County of Death<br><b>Allegany</b>   |   |
| 5. Social Security Number<br><b>220-16-6166</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>Month <b>Jun</b> Day <b>24</b> Year <b>1925</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
| Usual Residence of Decedent   |  |   |  |  |                                |  |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Cumberland</b>   |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>932 Seton Drive Apts.</b>  |  |   |  | 10f. Zip Code<br><b>21502</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br>X <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes X <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>retired secretary</b>  |                                | 16b. Kind of Business/Industry<br><b>fedl government</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>H. Clifford Spiker</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary K (Davidson)</b>  |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Bowman brother-in-law</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>504 Prince George St ;Cumberland, MD 21502</b>   |                                |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Mary's Cemetery</b>  |  | Date<br><b>3/29/</b>   |                                | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><i>James J Scarpelli</i>   |  |   |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home P.A.<br/>Cumberland, Maryland 21502</b>  |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br><br>b. <b>Urinary Tract Infection</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                                | Approximate Interval Between Onset and Death<br><br><b>5 days</b><br><br><b>5 days</b>   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b><br><b>Right Leg Gangrene</b>   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |                                |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |                                |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |                                |  |   |
| 29b. Signature and title of certifier<br><i>Thomas E. Chapell</i>   |  |   |  | 29c. License number<br><b>D35135</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>March 26, 1999</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas E. Chapell MD 912 Seton Dr Cumberland MD</b>  |  |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  |   |  | Registrar's Signature<br><i>[Signature]</i>  |                                |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12214

|   |   |   |  |  |                                |  |   |
|---|---|---|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Eloise Pearl Shipley</b>                               |   |  | 2. Date of Death<br>Month <b>Mar</b> Day <b>23</b> Year <b>1999</b>  |                                | 3. Time of Death<br><b>01:45pm</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Allegany County Nursing Home</b> |   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |                                | 4c. County of Death<br><b>Allegany</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-10-4189</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug 7, 1911</b> |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   |  |  |                                |  |   |
| Usual Residence of Decedent   |   |   |  |  |                                |  |   |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Cumberland</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>526 W. Industrial Blvd.</b>  |   |   |  | 10f. Zip Code<br><b>21502</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br><b>X</b> <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |                                | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>nfn</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>nmm</b>  |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William Shipley son</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>193 Nature Trail; Little River, SC 29566</b>   |                                |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park</b>   |  | Date<br><b>3/25/</b>   |                                | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><i>Michael J. Scarpelli</i>  |   |   |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home P.A.<br/>Cumberland, Maryland 21502</b>  |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebrovascular accident</b><br>Due to (or as a consequence of)<br><b>Cerebrovascular accident.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b></b><br>Due to (or as a consequence of):<br><b></b><br>Due to (or as a consequence of):<br><b></b> |   |   |  |  |                                |  |   |
| Approximate Interval Between Onset and Death<br><b>few hours</b><br><b>5 years.</b>   |   |   |  |  |                                |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus, Senile dementia</b><br><b>hypothyroidism</b>  |   |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |                                |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28d. Describe how injury occurred  |                                |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |                                |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |                                |  |   |
| 29b. Signature and title of certifier<br><b>V.A. Ranjithan</b>  |   |   |  | 29c. License number<br><b>D19750</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>Mar. 25, 1999</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>V.A. Ranjithan ; Furnace Street Ext. Cumberland MD 21502</b>   |   |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 25 1999</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |                                |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4  
ms

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cynthia A. Smith

2. Date of Death  
Month Day Year  
March 12 19993. Time of Death  
7:30pm

4a. Facility Name (If not institution, give street and number)

3102 Elmmede Road

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

220-36-0820

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct 18, 1939

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3102 Elmmede Road

10f. Zip Code

21042

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Mario Tonti

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth

unknown

19a. Informant's Name/Relationship (Type, Print)

Henry H. Smith/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3102 Elmmede Road Ellicott City, Maryland 21042

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

3-17-99

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Spen a Collins - Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Subarachnoid Hemorrhage

Approximate Interval Between Onset and Death

12 months

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. P. Farrell MD

29c. License number

D0018317

29d. Date signed (Month, Day, Year)

MAR 15 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERNARD P. FARRELL MD  
11055 LITTLE PATUXENT PARKWAY, COLUMBIA, MD 21044

31. Date filed (Month, Day, Year)

MAR 15 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12216

|  |   |                                       |   |  |  |  |   |  |   |  |
|--|---|---------------------------------------|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Helena Fay Salyers</b>                             |                                       |   |  | 2. Date of Death<br>Month Day Year<br><b>March 16, 1999</b>  |  |   |  | 3. Time of Death<br><b>3:59 am</b>                          |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Laurel Regional Hospital</b> |                                       |   |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>  |  |   |  | 4c. County of Death<br><b>Prince George's</b>               |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>404-20-9234</b>   |                                       | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |  | 8. Date of Birth<br>Month Day Year<br><b>Nov. 11, 1920</b>                                  |  | 9. Birthplace (State or Foreign Country)<br><b>Kentucky</b> |  |
|  | Usual Residence of Decedent   |                                       |   |  |  |  |   |  |   |  |
| 10a. State<br><b>Md.</b>   |   | 10b. County<br><b>Prince George's</b> |   | 10c. City, Town or Location<br><b>Laurel</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>14709 Bowie Road</b>  |   |                                       |   | 10f. Zip Code<br><b>20708</b>  |  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 12</b> College (1-4or 5+)  |   |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>                        |  |  |   | 16b. Kind of Business/Industry<br><b>Children's Store</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Fred Singleton</b>   |   |                                       |   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Minta Reynolds</b>  |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kay Berry / daughter</b>  |   |                                       |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12111 Dove Circle Laurel, Maryland 20708</b>   |  |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Double Springs Cemetery</b>  |  | Date<br><b>3/19/99</b>   |  | 20c. Location - City or Town, State<br><b>Waynesburg, Kentucky</b>                          |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                                       |   |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Avenue Laurel, Maryland 20707</b>  |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute Leukemia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br><br>Approximate Interval Between Onset and Death<br><b>unknown</b> |   |                                       |   |  |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>sepsis, pneumonia, urinary tract infection</b>  |   |                                       |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                       |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                       | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |                                       | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred                           |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                                       |   |  |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br>   |   |                                       |   |  | 29c. License number<br><b>D 23181</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3-16-99</b>                                       |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>R.G. BHOGRAJ, M.D. 704 Gorman Ave # T-1 Laurel, MD 20707</b>  |   |                                       |   |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1999</b>  |   |                                       | 32. Registrar's Signature<br>   |  |  |  |   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

7

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12217

|   |   |   |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|---|---|---|--------|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Leota Gosnell-Schmidt</b>                |   |  |  | 2. Date of Death<br>Month Day Year<br><b>March 30 1999</b>   |  | 3. Time of Death<br><b>12:30pm</b>   |  |   |   |   |        |  |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3425 Jay Drive</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Ellicott City</b> |  | 4c. County of Death<br><b>Howard</b>   |  |   |   |   |        |  |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-12-0434</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   | If Under 1 Year<br>Months Days                               | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct 7, 1921</b>                                      |  |   |   |   |        |  |  |  |  |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                             |   |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
| Usual Residence of Decedent   |   |   |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Ellicott City</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |   |        |  |  |  |  |  |  |
| 10e. Street and Number<br><b>3425 Jay Drive</b>   |   |   |  | 10f. Zip Code<br><b>21042</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |   |   |   |        |  |  |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |   |   |   |        |  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>  |  | 16b. Kind of Business/Industry<br><b>City Government</b>   |  |  |   |   |   |        |  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Allen Hussell Gosnell</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Marie Matilda Koehnlen</b>   |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LCDR. Leonard A. Schmidt/Son</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3502 North Chatham Road Ellicott City, MD 21042</b>                                      |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | Date<br><b>4-2-99</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |  |   |   |   |        |  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Sam Collins-Witzke</b>  |   |   |  | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD 21043</b>  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td rowspan="4">           {         </td> <td>a. <b>Metastatic Carcinoma of Left Breast</b><br/>Due to (or as a consequence of):</td> <td>Years.</td> </tr> <tr> <td>b. _____<br/>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. _____<br/>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____<br/>Due to (or as a consequence of):</td> <td></td> </tr> </table> |   |   |  |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | { | a. <b>Metastatic Carcinoma of Left Breast</b><br>Due to (or as a consequence of): | Years. | b. _____<br>Due to (or as a consequence of): |  | c. _____<br>Due to (or as a consequence of): |  | d. _____<br>Due to (or as a consequence of): |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | {   | a. <b>Metastatic Carcinoma of Left Breast</b><br>Due to (or as a consequence of):   | Years.   |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
|   |   | b. _____<br>Due to (or as a consequence of):  |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
|   |   | c. _____<br>Due to (or as a consequence of):  |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
|   |   | d. _____<br>Due to (or as a consequence of):  |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |   |   |   |        |  |  |  |  |  |  |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |   |        |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   |   |   |        |  |  |  |  |  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |   |        |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>N-B. Vellanki</b>   |   |   |  | 29c. License number<br><b>D 30469.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 1st, 1999.</b>   |  |  |   |   |   |        |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N B Vellanki, MD: 9055 Chevrolet Drive, #Suite 100, Ellicott City, MD 21042.</b>   |   |   |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>   |   | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |  |  |  |  |   |   |   |        |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 12218

Physician  
/Medical  
Examiner

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>Sally Swift</i>  |  | 2. Date of Death<br>Month Day Year<br><i>March 31 1999</i>                 |  | 3. Time of Death<br><i>1310</i>                  |  |
| 4a. Facility Name (If not institution, give street and number)<br><i>Howard County General Hospital</i> |  | 4b. City, Town, or Location of Death<br><i>Columbia</i>                    |  | 4c. County of Death<br><i>Howard</i>             |  |
| 5. Social Security Number<br><i>577-24-8268</i>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><i>85</i> Yrs. |  |
| 8. Date of Birth (Month, Day, Year)<br><i>Aug 17, 1913</i>  |  | 9. Birthplace (State or Foreign Country)<br><i>South Carolina</i>          |  |  |  |

Funeral  
Director

|   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| Usual Residence of Decedent   |  | 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Howard</i>   |  | 10c. City, Town or Location<br><i>Columbia</i>                          |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><i>5001 Still Corners</i>   |  | 10f. Zip Code<br><i>21044</i>   |  | 10g. Citizen of What Country?<br><i>United States</i>  |  |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i> |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Housekeeping</i>                    |  | 16b. Kind of Business/Industry<br><i>University</i>  |  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>James Brown</i>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Roxanne unknown</i>   |  |  |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Audrey Durr-Poole/Daughter</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>5001 Still Corners Columbia, Maryland 21044</i> |  |  |  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>West Park Cemetery</i>   |  | Date<br><i>4-7-99</i>  |  | 20c. Location - City or Town, State<br><i>Cleveland, Ohio</i>           |  |  |  |

To Be Completed by Funeral Director

|  |  |   |  |
|--|--|---|--|
| 21. Signature of Funeral Service Licensee<br><i>Sam A. Collins - Witzke</i>  |  | 22. Name and Address of Facility<br><i>Harry H. Witzke's Family Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD 21043</i> |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <i>Congestive Heart Failure</i><br>Due to (or as a consequence of):<br>b. <i>Mitral Regurgitation</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><i>2 days</i><br><i>2 years</i>   |  |

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |
|---|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Diabetes</i><br><i>Peripheral Vascular Disease</i>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><br>28b. Time of Injury<br><i>M</i><br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br><br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature] M.D.</i>  |  |
| 29c. License number<br><i>D50778</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>March 31, 1999</i>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Michelle Peice 1055 Little Portuxent Pkwy Columbia, MD 21046</i>   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 01 1999</i>   |  | 32. Registrar's Signature<br><i>[Signature] B. Sparks</i>   |  |

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12219

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |
|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>William H. Savoy</b>  |  | 2. Date of Death<br>Month Day Year<br><b>March 29, 1999</b>   |  | 3. Time of Death<br><b>4:45pm</b>  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>  |  | 4c. County of Death<br><b>Prince Georges</b>   |
| 5. Social Security Number<br><b>218-20-1953</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>May 14, 1925</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
| Usual Residence of Decedent  |  |   |  |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Prince Georges</b>                                       | 10c. City, Town or Location<br><b>Clinton</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>6307 Denlee Drive</b>   |  | 10f. Zip Code<br><b>20735</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
| 14. Race - American Indian, Black, White, etc.<br>Specify <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>  |  | 16b. Kind of Business/Industry<br><b>Boys Village</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>unknown</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Savoy</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Arietha Savoy- Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6307 Denlee Drive Clinton, Maryland 20735</b>   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. Marys Cemetery April 3, 1999</b>   |  | 20c. Location - City or Town, State<br><b>Croom, Maryland</b>  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Adams Funeral Home Aquasco, Maryland 20608</b>   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>SEPTIC SHOCK</b><br>Due to (or as a consequence of):<br><b>PERITONITIS</b><br>Due to (or as a consequence of):<br><b>ISCHEMIC COLITIS</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b><br><b>RENAL FAILURE</b><br><b>DIABETES MELLITUS</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospitel: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |
| 29b. Signature and title of certifier<br> MD  |  | 29c. License number<br><b>D53885</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/31/99</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. VENKAT S. RAMANAN 7501 SWIRATTS ROAD #307 CLINTON MD 20735</b>  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |  | 32. Registrar's Signature<br>   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12220**  
**Certificate of Death** Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charles Raymond Stanley</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>29</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>2:45 P.M.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Chesapeake Woods</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Dorchester</b>  |  | 4c. County of Death<br><b>Dorchester</b>   |  |
| 5. Social Security Number<br><b>217-10-8664</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 25, 1915</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Dorchester</b>   |  | 10c. City, Town or Location<br><b>Cambridge</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>525- Glenburn Avenue</b>   |  | 10f. Zip Code<br><b>21613</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seafood Picker</b>  |  | 16b. Kind of Business/Industry<br><b>Seafood Industry</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>George Stanley</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie Camper</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Alice Linthicum</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>602-Bradley Ave. Cambridge, MD. 21613</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Malone Cemetery</b>   |  | 20c. Date<br><b>4/03/99</b>   |  | 20d. Location - City or Town, State<br><b>Woolford, MD.</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Janelle C. Henry</b>   |  |
| 22. Name and Address of Facility<br><b>HENRY Funeral Home P.A.<br/>510 Washington St. Cambridge, MD. 21613</b>   |  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>metastatic prostate ca.</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |
| 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Armed Nawaz, MD</b>  |  |
| 29c. License number<br><b>D50987</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/31/99</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>105 Aurora Street Cambridge MD 21613</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |  |
| 32. Registrar's Signature<br><b>Benita B. Sparks</b>   |  |   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020 **2db**  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Earnest Carl Taylor

2. Date of Death

March 29, 1999

3. Time of Death

2:54 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

233-24-2021

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb 29, 1920

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3404 Weller Rd

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

1942-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer Assistant

16b. Kind of Business/Industry

Johns Hopkins University

17. Father's Name (First, Middle, Last)

Archie E. Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Nellie V. Judy

19a. Informant's Name/Relationship (Type, Print)

Gloria T. Taylor/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3404 Weller Rd, Silver Spring, MD 20906

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel United Methodist

Date

Apr 1

20c. Location - City or Town, State

Lively, VA

21. Signature of Funeral Service Licensee

▶ *Olaf Daniel*

22. Name and Address of Facility Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

Approximate Interval Between Onset and Death

2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Coronary Artery Disease

10 Years

Atherosclerotic Heart Disease

10 Years

Hypertension

20 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Giant Cell Arteritis

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *Francisco A. Matheus MD*

29c. License number

D41460

29d. Date signed (Month, Day, Year)

March 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francisco A. Matheus, MD 13018 Georgia Ave, Silver Spring, MD 20906

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

▶ *Benjamin B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Charles Franklin Taylor

2. Date of Death

March 31, 1999

3. Time of Death

3:30 p.m.

4a. Facility Name (If not institution, give street and number)

508 morgnec Road (Residence)

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

5. Social Security Number

219-34-3284

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 19, 1936

9. Birthplace (State or Foreign Country)

Price Station, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

508 Morgnec Road

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1960-1963

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Body Fender Mechanic

16b. Kind of Business/Industry

Auto

17. Father's Name (First, Middle, Last)

Elmer Coleman

18. Mother's Name (First, Middle, Maiden Surname)

Anna Mae Moore

19a. Informant's Name/Relationship (Type, Print)

Mary Ann Taylor/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

508 Morgnec Road, Chestertown, MD 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Church Hill Cemetery

Date

4/3/99

20c. Location - City or Town, State

Church, Hill, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein &amp; Newnam Funeral Home, P.A.

130 Speer Road, Chestertown, MD 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-13824

29d. Date signed (Month, Day, Year)

4-159

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John C. Seymour, 122 Speer Road, Chestertown, MD 21620

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

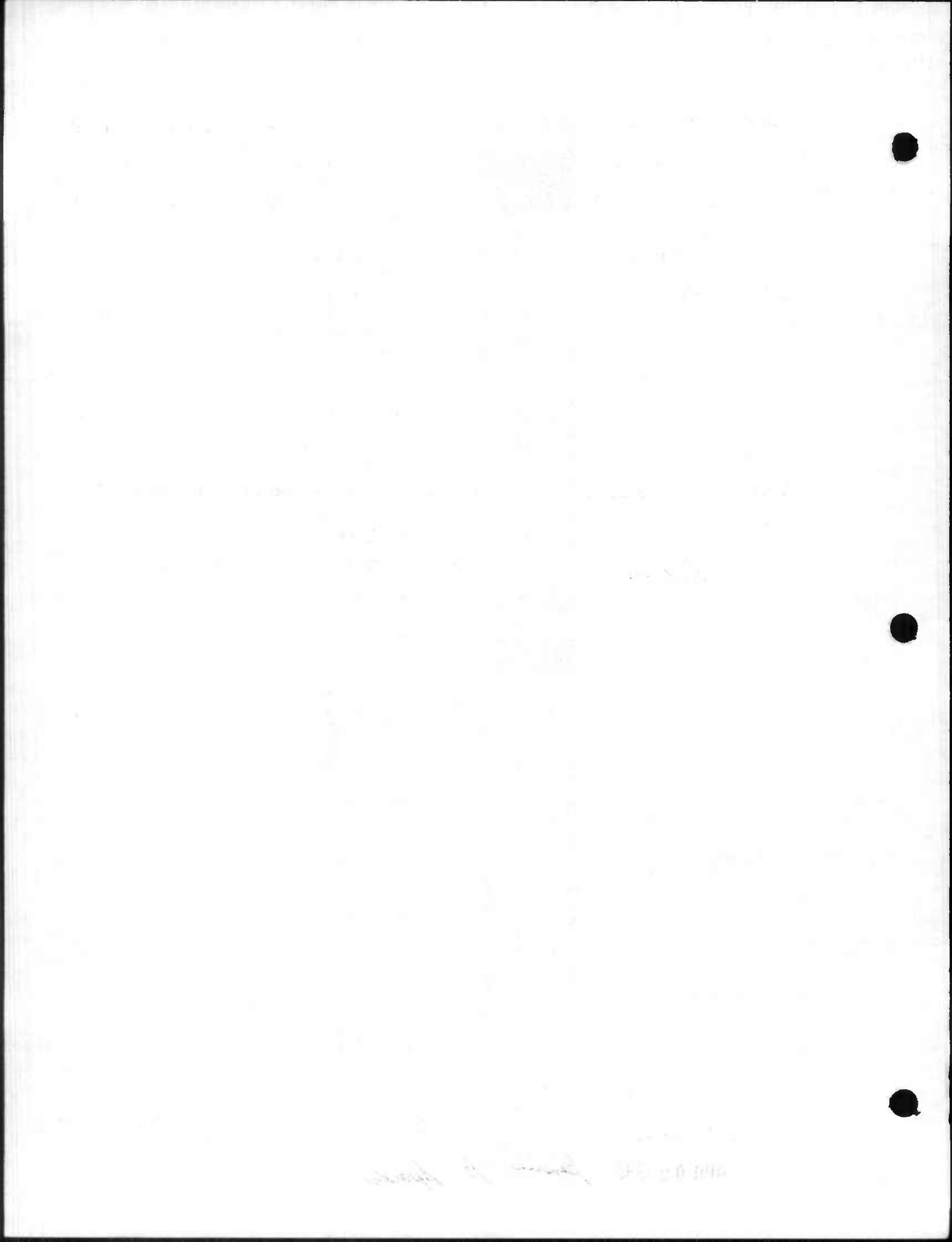
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



State of Maryland / Department of Health and Mental Hygiene 99 12223  
Certificate of Death Reg. No.

Reg. No.

DMMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 99 12224

Certificate of Death

Reg. No.

|   |  |                                 |   |   |  |   |  |  |   |  |
|---|--|---------------------------------|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>HENRY THOMAS TIBBS</b>                                    |                                 |   |   |  |   | 2. Date of Death<br>Month Day Year<br><b>March 29, 1999</b>                      |  | 3. Time of Death<br><b>7:45am</b>                           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b> |                                 |   |   |  |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>                          |  | 4c. County of Death<br><b>Baltimore</b>                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-20-3162</b>  |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 22, 1927</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |  |
|   | Usual Residence of Decedent  |                                 |   |   |  |   |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>5712 Daybreak Terrace</b>  |  |                                 |   | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1945-47</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machinist</b> |  |   | 16b. Kind of Business/Industry<br><b>Air Conditioning</b>                        |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Clyde Vernon Tibbs</b>  |  |                                 |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura Belle Waddell</b>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mildred O. Riley - Sister</b>  |  |                                 |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2933 Pocock Road, Monkton, MD 21111</b> |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Stanislaus Cemetery</b>  |   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  | 20d. Date<br><b>3/31/99</b>  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Howard K. McComas</b>   |  |                                 |   |   |  | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>50 W. Broadway, Bel Air, MD 21014</b>                   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Exacerbation of Chronic Obstructive Pulmonary Disease 5 Days</b><br>Due to (or as a consequence of):<br><b>b. Hypercapnea</b><br>Due to (or as a consequence of):<br><b>c. Left Upper Lobe Pneumonia</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |                                 |   |   |  |   |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |                                 |   |   |  |   |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                 |   |   |  |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |                                 |   |   |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>History of Right Upper Lobe Lobectomy<br/>For Tuberculosis, Hypertension, mild<br/>Dehydration</b>   |  |                                 |   |   |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                 | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |                                 | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how Injury occurred                           |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                                 |   |   |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>MD</b>  |  |                                 | 29c. License number<br><b>D0053617</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Hassan Nasser, 9000 Franklin Square Drive, Baltimore, MD 21237</b>   |  |                                 |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |  |                                 | 32. Registrar's Signature<br><b>B. Spitzer</b>  |   |  |   |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1. The first part of the report is a general  
description of the project and its objectives.  
It includes a brief history of the project and  
a statement of the purpose of the study.

2. The second part of the report is a detailed  
description of the methodology used in the study.  
It includes a description of the data collection  
methods and the statistical analysis used.

3. The third part of the report is a discussion  
of the results of the study. It includes a  
summary of the findings and a comparison of the  
results with previous studies. It also includes  
a discussion of the limitations of the study and  
some suggestions for future research.

4. The fourth part of the report is a conclusion  
and a list of references. The conclusion  
summarizes the main findings of the study and  
the references list the sources of information  
used in the study.

5. The fifth part of the report is a list of  
appendices. These include a list of the data  
collected, a list of the statistical tests used,  
and a list of the figures and tables included in  
the report.

6. The sixth part of the report is a list of  
acknowledgments. This section is used to  
thank the people and organizations that helped  
in the completion of the study.

7. The seventh part of the report is a list of  
the author's contact information. This includes  
the author's name, address, and telephone  
number.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12225

|  |  |  |   |  |                                |
|--|--|--|---|--|--------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>CARL DEAN TODD JR                      |  | 2. Date of Death<br>Month Day Year<br>MARCH 23 1999     |  | 3. Time of Death<br>9:40 AM    |
|  | 4a. Facility Name (If not institution, give street and number)<br>200 B CROCKER DR |  | 4b. City, Town, or Location of Death<br>BEL AIR         |  | 4c. County of Death<br>Harford |
| Funeral<br>Director  | 5. Social Security Number<br>218-12-0289   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>80 Yrs.               | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. |
|  | 8. Date of Birth (Month, Day, Year)<br>March 10, 1919                              |  | 9. Birthplace (State or Foreign Country)<br>N. Carolina |  |                                |
| Usual Residence of Decedent  |  |  |   |  |                                |
| 10a. State<br>Maryland   |  | 10b. County<br>Harford   |   | 10c. City, Town or Location<br>Bel Air   |                                |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |                                |
| 10e. Street and Number<br>200 B Crocker Dr.  |  | 10f. Zip Code<br>21014   |   | 10g. Citizen of What Country?<br>USA   |                                |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |   |  |                                |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Farmer  |   | 16b. Kind of Business/Industry<br>Dairy Farming  |                                |
| 17. Father's Name (First, Middle, Last)<br>Carl (nmn) Todd   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Eva (nmn) McKnight  |   |  |                                |
| 19a. Informant's Name/Relationship (Type, Print)<br>Michael C. Todd/ Son   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1910 White House Rd., Bel Air, MD 21015   |   |  |                                |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.  |   | 20c. Location - City or Town, State<br>3-24-99 Towson, Maryland  |                                |
| 21. Signature of Funeral Service Licensee<br>Howard K. McComas   |  | 22. Name and Address of Facility<br>Howard K. McComas III Funeral Home, P.A.<br>50 W. Broadway Street, Bel Air, Maryland 21014   |   |  |                                |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>ASCD<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |  |   |  |                                |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   |  |                                |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |                                |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |                                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DIABETES MELLITUS TYPE 2   |  |  |   |  |                                |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br>NA   |   | 28b. Time of Injury<br>NA M  |                                |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred<br>NA  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br>NA   |                                |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |   |  |                                |
| 29b. Signature and title of certifier<br>G. P. NABHU M.D.  |  | 29c. License number<br>OCME  |   | 29d. Date signed (Month, Day, Year)<br>MAR 23 1999   |                                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>G. P. NABHU M.D. 218 FOLLOWS AVE BEL AIR MD 21014  |  |  |   |  |                                |
| 31. Date filed (Month, Day, Year)<br>MAR 25 1999   |  | 32. Registrar's Signature<br>B. Spach  |   |  |                                |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





WRC  
99-1744-510  
ARTHUR  
THOMPSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEQ G770 4-29-99 <sup>WR</sup> Certificate of Death

Reg. No.

99 12226

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Arthur Franklin Thompson</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 23, 1999</b>  |                                | 3. Time of Death<br><b>8:56 PM.</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| 5. Social Security Number<br><b>216 74 2894</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 17, 1960</b>                                    |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |  |                                |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>ANNAPOLIS</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>69 OLD MILL BOTTOM ROAD</b>  |  |   |  | 10f. Zip Code<br><b>21401</b>  |                                | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>  |                                | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Allen E. Thompson Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Mae Soukp</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Allen Edward Thompson Jr./Brother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>69 OLD MILL BOTTOM ROAD ANNAPOLIS, MD. 21401</b>   |                                |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FT. LINCOLN CREMATORY</b>  |  | 20c. Date<br><b>03-30-99</b>   |                                | 20d. Location - City or Town, State<br><b>BRENTWOOD, MD.</b>                                   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home, Inc.<br/>147 Duke of Gloucester St. Annapolis, MD 21401</b>  |                                |  |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>MULTIPLE INJURIES</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Due to (or as a consequence of):</b><br><br><b>Due to (or as a consequence of):</b><br><br><b>Due to (or as a consequence of):</b> |  |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>3-23-99</b>   |  | 28b. Time of Injury<br><b>11:00</b> A M  |  |
| 28c. Injury at Work?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>CONSISTENT WITH BEING STRUCK WITH A BUCKET ATTACHED TO A CRANE</b>   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>WORKSITE</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>BREWERS CREEK, ANNE ARUNDEL CO. MD.</b>   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 24, 1999</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARY ANN B. JONES 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  | 32. Registrar's Signature<br>  |  |  |  |

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

*[Faint, illegible handwritten text]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12227

|  |   |   |   |  |  |  |   |  |
|--|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DOROTHY THOMPSON</b>   |   |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>31</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>12:30 AM</b>                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GOODWILL MENNONITE HOME</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>GRANTSVILLE</b>   |  | 4c. County of Death<br><b>GARRETT CO.</b>                               |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>162-22-2962</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 9, 1925</b>              | 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |
|  | Usual Residence of Decedent   |   |   |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>PA</b>   | 10b. County<br><b>SOMERSET Co.</b>  | 10c. City, Town or Location<br><b>BOYNTON</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>PO Box 29</b>  |   |   | 10f. Zip Code<br><b>15532</b>                    |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                     |  |  | 16b. Kind of Business/Industry<br><b>HOME</b>  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>IRVIN MURRAY</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VERA PETENBRINK</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>JANET HOCKARD</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>PO Box 29 BOYNTON, PA 15532</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>APOSTOLIC CHURCH CEME.</b>   |  | Date<br><b>4-2-99</b>  |  | 20c. Location - City or Town, State<br><b>MEYERSDALE, PA 15552</b>      |  |
|  | 21. Signature of Funeral Service Licensee<br><b>William L. Price</b> FD-011249-L  |   |   |  | 22. Name and Address of Facility<br><b>W. R. PRICE FUNERAL HOME INC<br/>325 MAIN ST MEYERSDALE PA 15552</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Endstage Chronic Obstructive Pulmonary Disease 6 months</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |  |   | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pneumonia</b><br><b>Coronary Artery Disease.</b>   |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>J. E. Blom</b>  |   | 29c. License number<br><b>34079</b>              |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 31 1999</b>                                    |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James E. Beitelmo Grantsville MD 21536</b>  |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

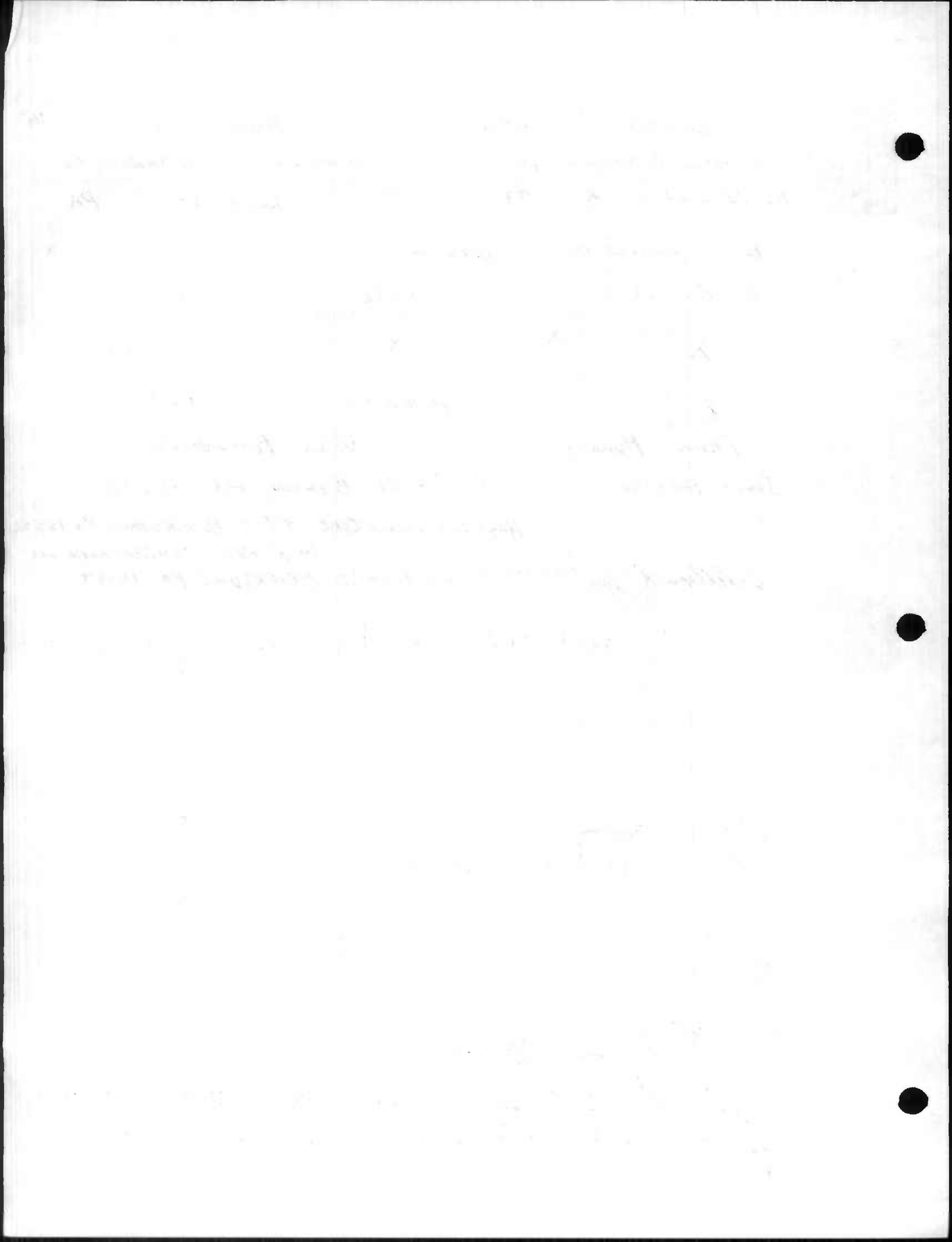
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12228

Amended item #1 & 17 4/2/99 WCHD 4/2/99 cle  
Amended item #1 per Phy. 4/1/1999 Jrd WCHD Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)  
Joushua Joushua  
Joushua James Taylor JR.  
2. Date of Death  
Month Day Year  
March 26 1999  
3. Time of Death  
2058

Funeral  
Director

4e. Facility Name (If not institution, give street and number)  
PENINSULA REGIONAL MEDICAL CENTER  
4b. City, Town, or Location of Death  
SALISBURY  
4c. County of Death  
WICOMICO  
5. Social Security Number  
218-48-8269  
6. Sex  
M ☒ F ☐  
7. Age (In yrs. last birthday)  
50 Yrs.  
If Under 1 Year  
Months Days  
If Under 24 Hrs.  
Hours Min.  
8. Date of Birth  
(Month, Day, Year)  
Oct. 12 1948  
9. Birthplace (State or Foreign Country)  
Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent  
10e. State  
Maryland  
10b. County  
Wicomico  
10c. City, Town or Location  
Quantico  
10d. Inside City Limits  
1 ☐ Yes 2 ☒ No  
10e. Street and Number  
23760 Head Of Creek Road  
10f. Zip Code  
21856  
10g. Citizen of What Country?  
U.S.A  
11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced  
12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 77-79  
13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian,  
Black, White, etc.  
Specify: Black  
15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12)  
College (1-4 or 5+)  
5+  
16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
Social Worker  
16b. Kind of Business/Industry  
None  
17. Father's Name (First, Middle, Last)  
Joushua  
Joushua James Taylor SR.  
18. Mother's Name (First, Middle, Maiden Surname)  
Dorothy Goslee Taylor  
19a. Informant's Name/Relationship (Type, Print)  
Dorothy Jones (Daughter)  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
3705 Keyhole Ct. Forestville Md. 20746  
20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Head Of Creek Cemetery  
20c. Location - City or Town, State  
Quantico, Md.  
21. Signature of Funeral Service Licensee  
Gladys B. Stewart  
22. Name and Address of Facility  
Stewart Funeral Home  
821 West Rd. Salisbury, Md. 21801

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final  
disease or condition  
resulting in death)  
e. Sepsis  
Due to (or as a consequence of):  
b. Peritonitis  
Due to (or as a consequence of):  
c. Ruptured Gastric Ulcer  
Due to (or as a consequence of):  
d.   
Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last  
23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown  
24a. Was an autopsy  
performed?  
1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings  
available prior to  
completion of causa  
of death?  
1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malignant T. Cell Lymphoma.

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No  
26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)  
27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined  
28a. Date of Injury  
(Month, Day Year)  
28b. Time of  
Injury  
M  
28c. Injury et  
Work?  
1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)  
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier  
Gladys B. Stewart  
29c. License number  
D29105  
29d. Date signed (Month, Day, Year)  
3/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
Christopher Huddleston, M.D. 106 Milford ST SALISBURY, MD

31. Date filed (Month, Day, Year)  
MAR 30 1999  
32. Registrar's Signature  
B. Sparks

State  
Registrar

218-48-8269  
Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Joshua Taylor  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEO G770 4-16-99 W

Certificate of Death

Reg. No.

99 12229

|  |   |   |  |   |   |  |  |   |
|--|---|---|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>BILLY B. TAYLOR</b>                          |   |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 05, 1999</b> |  | 3. Time of Death<br><b>11:50 AM</b>    |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>    |  | 4c. County of Death<br><b>WICOMICO</b> |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-20-4440</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 8, 1927</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
|  | Usual Residence of Decedent   |   |  |   |   |  |  |   |
| 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>WICOMICO</b>  |  | 10c. City, Town or Location<br><b>FRUITLAND</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |
| 10e. Street and Number<br><b>218 HAYWARD AVE.</b>  |   |   |  | 10f. Zip Code<br><b>21826</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates: <b>NAVY</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALESMAN RETAIL</b>   |   | 16b. Kind of Business/Industry<br><b>RETAIL</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>GEORGE W. TAYLOR</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ERMA B. SHOCKLEY</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>STEPHEN C. TAYLOR - SON</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>336 PINE VALLEY RD. DOVER, DE 19904</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WICOMICO MEMORIAL PARK</b>   |  | Date<br><b>4/9/99</b>   |   | 20c. Location - City or Town, State<br><b>SALISBURY, MARYLAND</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br><b>B. Keet Physical CFSP</b>  |   |   |  | 22. Name and Address of Facility<br><b>705 E. MAIN ST. SALISBURY, MD 21804</b>  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE CAUSED BY MULTIPLE INJURIES</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |   |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |   |  |   |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>APRIL 05, 1999</b>   |  | 28b. Time of Injury<br><b>11:10</b> A M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
| 28d. Describe how injury occurred<br><b>SUBJECT DRIVER OF VEHICLE, RAN OFF ROAD &amp; OVERTURNED IN POND.</b>  |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>   |   |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Rt. 756</b>   |   |   |  |   |   |  |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |   |   |  |  |   |
| 29b. Signature and title of certifier<br><b>Theodore M. King</b>   |   |   |  | 29c. License number<br><b>OCME</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 06, 1999</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 9 1999</b>   |   |   |  | 32. Registrar's Signature<br><b>B. Spaw</b>   |   |  |  |   |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12230**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys Virginia Umberger

2. Date of Death

Month Day Year  
March 31 1999

3. Time of Death

2:30 pm

4a. Facility Name (If not institution, give street and number)

National Lutheran Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

220-42-0336

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jul 29 1911

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9527 Veirs Drive, #3

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Secretarial

17. Father's Name (First, Middle, Last)

David Levi Andes

18. Mother's Name (First, Middle, Maiden Surname)

Emma Cline

19a. Informant's Name/Relationship (Type, Print)

Ernest J. Umberger / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9527 Veirs Drive, #3, Rockville, MD 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

4-2-99

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

Collins Funeral Home  
500 University Blvd, West, Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

b.

Demented Alzheimer's

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

1 week

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Polyneuritis Rheumatica, Hypertension  
Arteriosclerotic Coronary Artery Disease  
Epilepsy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

036618

29d. Date signed (Month, Day, Year)

April 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Schemm, 9701 Veirs Drive, Rockville, MD 28550

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12231

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Florence Virginia Vaughan</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 20 1999</b>   |  | 3. Time of Death<br><b>0105</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>  |  | 4c. County of Death<br><b>Cecil</b>  |  |
| 5. Social Security Number<br><b>215-18-2642</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>03-23-9124</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Edgewood</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>414 Kennard Ave.</b>   |  | 10f. Zip Code<br><b>21040</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>11 Years</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Commisary Supervisor</b>  |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Clinton Curry</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Myrtle Sampson</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Vernon T. Vaughan(Husband)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>414 Kennard Ave. Edgewood, Maryland 21040</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Angel Hill Cemetery</b>  |  | Date<br><b>3-24-99</b>   |  | 20c. Location - City or Town, State<br><b>Havre de Grace, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Mitchell-Smith Funeral Home P.A.<br/>123 S. Washington St. Havre de Grace, MD 21078</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br><br>b. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>c. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br><br>d. |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D29221</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 22, 1999</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gary Beste, M.D. 313 W. Main St. #A Newark, DE 19711</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 25 1999</b>   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

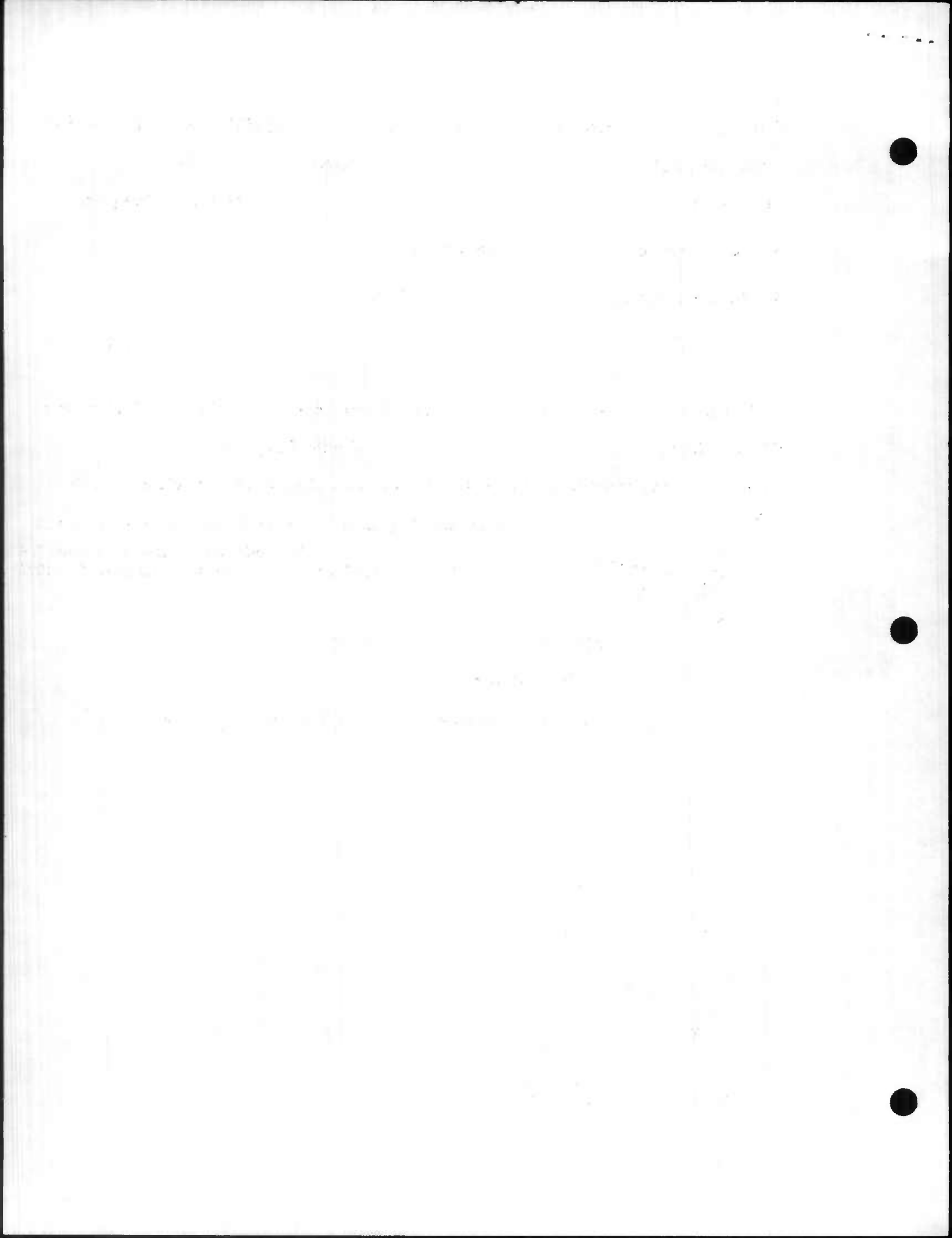
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12232

|   |  |   |   |   |   |  |   |  |   |  |  |
|---|--|---|---|---|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>George J. Voll Sr.</u>                      |   |   |   | 2. Date of Death<br>Month <u>March</u> Day <u>12</u> Year <u>1999</u> |  |   |  | 3. Time of Death<br><u>~ 2 PM</u>                           |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>5006 Alice Avenue</u> |   |   |   | 4b. City, Town, or Location of Death<br><u>Ellicott City</u>          |  |   |  | 4c. County of Death<br><u>Howard</u>                        |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>214 26 9281</u>  |   | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><u>69</u> yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><u>June 11, 1929</u>             |  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u> |  |  |
|   | Usual Residence of Decedent  |   |   |   |   |  |   |  |   |  |  |
| 10a. State<br><u>Maryland</u>   |  | 10b. County<br><u>Howard</u>  |   | 10c. City, Town or Location<br><u>Ellicott City</u>   |   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 10e. Street and Number<br><u>5006 Alice Avenue</u>  |  |   |   | 10f. Zip Code<br><u>21043</u>   |   | 10g. Citizen of What Country?<br><u>United States</u>                    |   |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>Korean</u> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u> <u>12</u>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Technician</u>  |   |  |   | 16b. Kind of Business/Industry<br><u>Computer</u>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>Charles E. Voll</u>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Madeline Franey</u>   |   |  |   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Margaret A. Voll/Wife</u>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>5006 Alice Avenue Ellicott City, MD 21043</u>   |   |  |   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Meadowridge Cemetery</u>   |   | 20c. Location - City or Town, State<br><u>3-16-99 Elkridge, Maryland</u> |   |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><u>Stanley M. Loewner</u>  |  |   |   | 22. Name and Address of Facility<br><u>Harry H. Witzke's Family Funeral Home, Inc.</u><br><u>4112 Old Columbia Pike Ellicott City, MD 21043</u>   |   |  |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Asphyxia by Hanging</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |  |   |   |   |   |  |   |  |   | Approximate Interval Between Onset and Death<br><u>minutes</u>     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>depression</u>   |  |   |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |   |   | 28a. Date of Injury (Month, Day, Year)<br><u>Mar 12, 1999</u>   |   | 28b. Time of Injury<br><u>~ 2 P M</u>                                    |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred<br><u>Self-inflicted hanging</u> |  |
|   |  |   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><u>home</u>   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><u>Same as above</u>   |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |   |   |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br><u>Patricia A. Tate, MD</u>  |  |   |   | 29c. License number<br><u>D31473</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>Mar 13, 1999</u>               |   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>PATRICIA A. TATE, MD 4565 Hemlock Cone Way Ellicott City, MD 21042</u>   |  |   |   |   |   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>MAR 15 1999</u>   |  |   |   | 32. Registrar's Signature<br><u>B. Sparks</u>   |   |  |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Reg. No.

Amend #7, 3/29/99, JW, Montg. Co.

## Certificate of Death

99 12233

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ahmed Seray Wurie

2. Date of Death

Month Day Year  
March 21, 1999

3. Time of Death

5:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

212-31-6265

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 ~~51~~ Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 7, 1948

9. Birthplace (State or Foreign)

Republic of  
Sierra Leone

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14136 Grand Pre Road, #24

10f. Zip Code

20906

10g. Citizen of What Country?

Republic of  
Sierra Leone

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bank Officer

16b. Kind of Business/Industry

Central Bank  
of Freetown

17. Father's Name (First, Middle, Last)

Alijah Wurie

18. Mother's Name (First, Middle, Maiden Surname)

Mantos Eastmon Noah

19a. Informant's Name/Relationship (Type, Print)

Carrillion Samison-Wurie (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14136 Grand Pre Road, #24, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

3-30-99

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Coronary Insufficiency

Due to (or as a consequence of):

Ruptured Abdominal Aortic Aneurysm Postop

3 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atelectasis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D14545

29d. Date signed (Month, Day, Year)

March 21, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Sulkin, M.D., 9715 Medical Center Drive, #105, Rockville, Maryland 20850

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Released By: MEO Carl Margolis, M  
Division of Vital Records, P.O. Box 68760,permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12234

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRNE L

WARNER

2. Date of Death

Month  
MARCHDay  
25Year  
1999

3. Time of Death

1:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

184-24-7661

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year  
May 19, 1931

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3931 Wendy Lane

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Kania

18. Mother's Name (First, Middle, Maiden Surname)

Stella Maziasz

19a. Informant's Name/Relationship (Type, Print)

Thomas B. Warner / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3931 Wendy Lane, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

03/29/99 Silver Spring, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. Ken Skala

22. Name and Address of Facility

Collins Funeral Home, Inc.  
500 University Blvd W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DILATED CARDIOMYOPATHY

Due to (or as a consequence of):

7 YEARS

c. MITRAL VALVE INSUFFICIENCY

Due to (or as a consequence of):

7 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospitel:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael R. DeBridges MD

29c. License number

D01138

29d. Date signed (Month, Day, Year)

MARCH 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL R DeBridges 413975 Connecticut Ave, Silver Spring, MD 20906

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12235

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>HAZEL WEEDON</b>   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>27</b> Year <b>99</b>   |  | 3. Time of Death<br><b>1040A</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Columbia MD</b>  |  | 4c. County of Death<br><b>Howard</b>   |
| 5. Social Security Number<br><b>215-34-8676</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 9, 1937</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
| Usual Residence of Decedent   |  |   |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Howard</b>   | 10c. City, Town or Location<br><b>Glenwood</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>3332 Route 97</b>  |  | 10f. Zip Code<br><b>21738</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (14 or 5+)   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>   |  | 16b. Kind of Business/Industry<br><b>Howard County Schools</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lester Dutton</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn Miles</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathleen Price (Daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3332 Route 97, Glenwood, MD 21738</b>   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bushy Park Cem.</b>  |  | 20c. Location - City or Town, State<br><b>4/1/99 Cooksville, MD</b>  |
| 21. Signature of Funeral Service Licensee<br><i>George R. Browder</i>   |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Anoxic Encephalopathy</b><br>Due to (or as a consequence of):<br>b. <b>END STAGE RENAL DISEASE</b><br>Due to (or as a consequence of):<br>c. <b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>March 27, 1999</b>   |  | 28b. Time of Injury<br><b>M</b>  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |
| 29b. Signature and title of certifier<br><i>William Savary</i>  |  | 29c. License number<br><b>D42465</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 27, 1999</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William Savary MD. 2 Knoll North Dr. Columbia MD 21045</b>   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |  | 32. Registrar's Signature<br><i>James B. Sparks</i>   |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12236

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LENA WEINSTOCK

2. Date of Death

04.01.1999

Year

3. Time of Death

7:45 AM

4a. Facility Name (If not institution, give street and number)

ARDEN COURT NURSING HOME

4b. City, Town, or Location of Death

POTOMAC

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

048.38.0597

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 5, 1909

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

POTOMAC

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10714 POTOMAC TENNIS LANE

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ADOLPH ROBINSON

18. Mother's Name (First, Middle, Maiden Surname)

SOPHIE GERINGER

19a. Informant's Name/Relationship (Type, Print)

DR. ALAN WEINSTOCK/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9108 CRANFORD DRIVE, POTOMAC, MARYLAND 20854

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TEMPLE BETH EL CEMETERY

Date

4.4.99

20c. Location - City or Town, State

STAMFORD, CT

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Chronic obstructive Pulmonary Disease

Approximate Interval Between Onset and Death

year

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20576

29d. Date signed (Month, Day, Year)

April 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Toni Schatzman 1410 S George Ave Bethesda MD 20814

State  
Registrar

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12237

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |   |  |
|--|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Janet S Welsh</b>  |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>29</b> Year <b>1999</b> |  | 3. Time of Death<br><b>6:46 PM</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Rockville MD</b>           |  | 4c. County of Death<br><b>Montgomery</b>                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>202-07-7407</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>March 3, 1917</b> | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |
|  | Usual Residence of Decedent   |   |  |  |   |  |   |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Derwood</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>7416 Cliffbourne Court</b>  |   |   |  | 10f. Zip Code<br><b>20855</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Physicist</b>  |   | 16b. Kind of Business/Industry<br><b>NIH</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry William Snyder</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Nelda Hummel</b>   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Mauzy (Daughter)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17416 Taunton Drive, Gaithersburg, MD 20877</b>  |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>3/30/99</b>   |   | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Drive</b><br><b>Gaithersburg, MD 20877</b>   |   |  |   |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>Aspiration pneumonia -</b><br>Due to (or as a consequence of):<br>b. <b>Hypoglycemia</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Idiopathic cirrhosis</b><br><b>Perforated Duodenal ulcer</b><br><b>Renal insufficiency</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                       |  | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                              |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><b>Eui G. Bellad MD.</b>   |  | 29c. License number<br><b>D52000</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1999</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>9711 Medical Center Drive Suite 308 Rockville, Maryland</b>   |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 02 1999</b>  |   | 32. Registrar's Signature<br>                                 |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12238

|  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>CAROLYN ROSE WERMIEL                                 |  |  |  | 2. Date of Death<br>Month Day Year<br>MARCH 25, 1999 |   | 3. Time of Death<br>8:45 PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE ADVENTIST HOSPITAL |  |  |  | 4b. City, Town, or Location of Death<br>ROCKVILLE    |   | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-46-7337   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>48 Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br>FEB. 2, 1951                                  |  |
|  | 9. Birthplace (State or Foreign Country)<br>WASHINGTON, DC                                       |  | 10a. State<br>MARYLAND   |  | 10b. County<br>MONTGOMERY                            |   | 10c. City, Town or Location<br>GAITHERSBURG  |  |
| Usual Residence of Decedent  |  |  |  |  |  |   |  |  |
| 10a. State<br>MARYLAND   |  |  | 10b. County<br>MONTGOMERY  |  |  | 10c. City, Town or Location<br>GAITHERSBURG   |  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  | 10e. Street and Number<br>16635 SHEA LANE  |  |  | 10f. Zip Code<br>20877  |  |  |
| 10g. Citizen of What Country?<br>UNITED STATES   |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4                               |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER   |  |  | 16b. Kind of Business/Industry<br>OWN HOME   |  |  | 17. Father's Name (First, Middle, Last)<br>LYONS ROSE   |  |  |
| 18. Mother's Name (First, Middle, Maiden Summa)<br>ANNETTE LUNCH   |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>JARED S. WERMIEL (HUSBAND)   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16635 SHEA LANE - GAITHERSBURG, MARYLAND 20877       |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MENORAH GARDENS  |  |  | 20c. Location - City or Town, State<br>3/29/99 ROCKVILLE, MARYLAND  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852   |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. STAPHYLOCOCCAL SEPSIS<br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>SYSTEMIC LUPUS ERYTHEMATOSUS   |  |  |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M                             |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |
| 29b. Signature and title of certifier<br> MD  |  |  | 29c. License number<br>D26540  |  |  | 29d. Date signed (Month, Day, Year)<br>MAR 26, 1999   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>CARL L. SCHAENBERGER 16220 Frederick Rd Gaithersburg MD  |  |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 30 1999   |  |  | 32. Registrar's Signature<br>  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12239

Amend #17, #18, 4/1/99, BMW, Montg. Co

Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
|--|--|---|---|--|--|---|---|---|---|---|--|---|----------------|--------|----------------------------------|--|-------------|----------|----------------------------------|--|-----------------|----------|----------------------------------|--|----|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Reba Margaret Harper Williams  |   |   |  |  | 2. Date of Death<br>Month Day Year<br>March 25, 1999  |   |   | 3. Time of Death<br>4:20 PM                       |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Rehabilitation & Nursing Center   |   |   |  |  | 4b. City, Town, or Location of Death<br>Silver Spring |   |   | 4c. County of Death<br>Montgomery                 |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>281-18-4803   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br>96 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>March 18, 1903   |   | 9. Birthplace (State or Foreign Country)<br>Ohio  |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
|  | Usual Residence of Decedent  |   |   |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Frederick                      |   | 10c. City, Town or Location<br>Frederick |  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 10e. Street and Number<br>796-C Wembley Drive  |  |   |   |  | 10f. Zip Code<br>21701   |   |   | 10g. Citizen of What Country?<br>United States  |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+) 5+   |  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |   |   | 16b. Kind of Business/Industry<br>Own Home  |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>George Sylvester Morlin Harper  |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Luella Ward Florence Ward   |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Luella W. Mast (daughter)  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>809 Hobbs Drive, Silver Spring, Maryland 20904-6252   |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  |  | 20c. Date<br>3-27-99                                  |   | 20d. Location - City or Town, State<br>Beltsville, Maryland   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Carol A. Delm   |  |   |   |  | 22. Name and Address of Facility<br>Rapp Funeral Services, P.A.<br>933 Gist Avenue, Silver Spring, Maryland 20910  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td rowspan="4">Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td rowspan="4">{</td> <td>a. Dehydration</td> <td>1 week</td> </tr> <tr> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b. Anorexia</td> <td>2 months</td> </tr> <tr> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Hip Fracture</td> <td>2 months</td> </tr> <tr> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table> |  |   |   |  |  |   |   |   |   | Immediate Cause (Final disease or condition resulting in death) | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | { | a. Dehydration | 1 week | Due to (or as a consequence of): |  | b. Anorexia | 2 months | Due to (or as a consequence of): |  | c. Hip Fracture | 2 months | Due to (or as a consequence of): |  | d. |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | {   | a. Dehydration  | 1 week                                   |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
|  |  |   | Due to (or as a consequence of):  |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
|  |  |   | b. Anorexia   | 2 months                                 |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
|  |  |   | Due to (or as a consequence of):  |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| c. Hip Fracture  | 2 months   |   |   |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| Due to (or as a consequence of):   |  |   |   |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| d.   |  |   |   |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Cerebrovascular Accident<br>Aortic Stenosis  |  |   |   |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   | 28a. Date of Injury (Month, Day, Year)<br>Jan. 21, 1999   |  | 28b. Time of Injury<br>6:30P M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred<br>Fell at home |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>At Home  |  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>796-C Wembley Dr, Frederick, MD  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 29b. Signature and title of certifier<br>Patricia L. Tomsco, MD  |  |   |   |  | 29c. License number<br>D51916  |   |   | 29d. Date signed (Month, Day, Year)<br>March 26, 1999   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Patricia L. Tomsco, M.D. 11140 Rockville Pike, #348, Rockville, MD 20852   |  |   |   |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 29 1999   |  | 32. Registrar's Signature<br>Benita B. Sparks |   |  |  |   |   |   |   |   |  |   |                |        |                                  |  |             |          |                                  |  |                 |          |                                  |  |    |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

99 12240

|  |  |   |  |  |   |  |  |   |
|--|--|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EARL JOSEPH WILSON</b>                                  |   |  |  | 2. Date of Death<br>Month <b>MAR</b> Day <b>27</b> Year <b>1999</b> |  | 3. Time of Death<br><b>1:04 AM</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>             |  | 4c. County of Death<br><b>MONTGOMERY</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-09-6886</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   | If Under 1 Year<br>Months Days                                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 2, 1917</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON D.C.</b>  |
|  | Usual Residence of Decedent  |   |  |  |   |  |  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>ROCKVILLE</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>10201 GROSVENOR PLACE</b>   |  |   |  | 10f. Zip Code<br><b>20852</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>4+</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FOREIGN SERVICE OFFICER</b>  |   | 16b. Kind of Business/Industry<br><b>STATE DEPARTMENT</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>JOSEPH M. WILSON</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VIRGINIA MAUDE LONG</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LORANE ANDREWS WILSON WIFE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10201 GROSVENOR PLACE, ROCKVILLE, MD 20852</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>NATIONAL CREMATORY</b>   |  | Date<br><b>3/31/99</b>   |   | 20c. Location - City or Town, State<br><b>FALLS CHURCH, VA</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>JOSEPH GAWLER'S SONS INC. 5130 WISCONSIN AVENUE NW, WASHINGTON, D.C. 20016</b>  |   |  |  |   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>194374-1 (NY)</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL D. KANE, LCDR, MC, USN</b>   |  |   |  | <b>NATIONAL NAVAL MEDICAL CENTER<br/>BETHESDA MD 20889-5600</b>  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>  |  | 32. Registrar's Signature<br>   |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT WILSON

2. Date of Death

Month Day Year  
March 28 1999

3. Time of Death

1:30 a.m.

4a. Facility Name (If not institution, give street and number)

Manor Care - Chevy Chase

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

081-10-2154

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11 07 1908

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yea ☒ No

10e. Street and Number

12817 Holdridge Road

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates: 43-4613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

+5

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Henry N. Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Cavanaugh

19a. Informant's Name/Relationship (Type, Print)

Mary Virginia Wilson / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12817 Holdridge Road, Silver Spring, MD 20906

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Darlington Cemetery

Date

3-31-99

20c. Location - City or Town, State

Darlington, MD

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Collins Funeral Home  
500 University Blvd West, Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Bronchopneumonia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Intractable Intestinal Obstruction

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jonathan Musher m

29c. License number

D33357

29d. Date signed (Month, Day, Year)

3/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee Jonathan Musher m 5530 Wisconsin Ave Chevy Chase MD

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

pennit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-691-2000.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12242

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Zina M. Wisniewski

2. Date of Death

Month Day Year  
March 25 1999

3. Time of Death

9:39 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7108 Central Avenue

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

577-48-8181

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 20, 1928

9. Birthplace (State or Foreign Country)

Latvia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7108 Central Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Vice President

16b. Kind of Business/Industry

Dental

17. Father's Name (First, Middle, Last)

Carl Mazins

18. Mother's Name (First, Middle, Maiden Surname)

Anna Schwartz

19a. Informant's Name/Relationship (Type, Print)

Joseph H. Wisniewski/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7108 Central Avenue, Takoma Park, Maryland 20912

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

3/27/99

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc., 500 University Blvd, West, Silver Spring, MD 20901

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

8 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

8 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

022309

29d. Date signed (Month, Day, Year)

March 26, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Phillip W. Poth, M.D., 9013 Flower Avenue, Silver Spring, Md. 20901

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12243

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ann B. Wohlever

2. Date of Death

Month Day Year  
March 27, 1999

3. Time of Death

6:16 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

107-18-4124

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 25, 1909

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State  
Connecticut10b. County  
Fairfield10c. City, Town or Location  
Brookfield

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

49 Arapaho Road

10f. Zip Code

06804

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Person

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Rudolph Klier

18. Mother's Name (First, Middle, Maiden Surname)

Anna Stolba

19a. Informant's Name/Relationship (Type, Print)

John Wohlever/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

49 Arapaho Road, Brookfield, Connecticut 06804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Central Cemetery

Date

March 31, 1999

20c. Location - City or Town, State

Brookfield, Connecticut

21. Signature of Funeral Service Licensee

William A. Humphrey MO1173

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Intracranial bleed

11 Days

Due to (or as a consequence of):

b. Carotid stenosis

15 Days

Due to (or as a consequence of):

c. Hypertension

Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jody E Green MD

29c. License number

D0052444

29d. Date signed (Month, Day, Year)

03-29-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jody E. Green, M.D. 8218 Wisconsin Avenue, Suite P14, Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25



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State of Maryland / Department of Health and Mental Hygiene 99 12244

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |   |   |  |  |
|--|--|---|--|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Roy C. Woodruff</b>                         |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>29</b> Year <b>1999</b> |   | 3. Time of Death<br><b>1:15 AM</b>                          |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>               |   | 4c. County of Death<br><b>Montgomery</b>                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-09-2168</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 31, 1908</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>                          |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>                                      |   | 10c. City, Town or Location<br><b>Chevy Chase</b>           |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>5043 Bradley Blvd.</b>  |   | 10f. Zip Code<br><b>20815</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Purchasing Agent</b>  |  | 16b. Kind of Business/Industry<br><b>Utility Company</b>   |   |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Garland Woodruff</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margretta Burch</b>  |   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William L. May, Jr./Step Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4217 Kenny Street, Beltsville, Maryland 20705</b>  |   |   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>   |   | 20d. Date<br><b>April 1, 1999</b>   |   |  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M00198</b>   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.</b><br><b>7557 Wisconsin Avenue</b><br><b>Bethesda, Maryland 20814-3501</b>   |  |  |   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Right Middle Cerebral Artery Stroke</b><br>Due to (or as a consequence of):<br>b. <b>Brain Stem Herniation</b><br>Due to (or as a consequence of):<br>c. <b>Dysphagia</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |   |   |   | Approximate Interval Between Onset and Death<br><br>4 days<br><br>1 day  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension, Atrial Fibrillation</b><br><br><b>Coronary Artery Disease, Prostate Cancer</b>  |  |   |  |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><br><b>Albert K. Lee, M.D.</b>  |  | 29c. License number<br><b>D31282</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>03/29/99</b>                                      |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Albert K. Lee, M.D. 8218 Wisconsin Avenue #105, Bethesda, Maryland 20814</b>  |  |   |  |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>  |  | 32. Registrar's Signature<br><br><b>Geneva G. Sparks</b>  |  |  |   |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12245

|   |   |  |  |  |  |                                      |   |                                   |  |  |
|---|---|--|--|--|--|--------------------------------------|---|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Musson Clementi Wainwright  |  |  |  | 2. Date of Death<br>Month Day Year<br>March 30, 1999   |                                      |   |                                   | 3. Time of Death<br>0240   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Kent & Queen Anne's Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Chestertown  |                                      |   |                                   | 4c. County of Death<br>Kent  |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-76-4695  |  | 6. Sex<br>M F  |  | 7. Age (In yrs. last birthday)<br>77 Yrs.  |                                      | 8. Date of Birth (Month, Day, Year)<br>October 18, 1921 |                                   | 9. Birthplace (State or Foreign Country)<br>Bermuda  |  |
|   | Usual Residence of Decedent   |  |  |  |  |                                      |   |                                   |  |  |
| To Be Completed by Funeral Director   | 10e. State<br>Maryland  |  | 10b. County<br>Kent  |  | 10c. City, Town or Location<br>Chestertown   |                                      |   |                                   | 10d. Inside City Limits<br>XX Yes 20 No  |  |
|   | 10e. Street and Number<br>203 Greenwood Avenue  |  |  |  | 10f. Zip Code<br>21620   |                                      | 10g. Citizen of What Country?<br>USA                    |                                   |  |  |
|   | 11. Marital Status<br>10 Never Married 20 Married<br>30 Widowed 40 Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>10 Yes 20 No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>10 Yes 20 No Specify:        |                                      |   |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>12   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Yacht Broker                    |                                      |   |                                   | 16b. Kind of Business/Industry<br>Marine   |  |
|   | 17. Father's Name (First, Middle, Last)<br>John Darrell Wainwright  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Amy Toker Clementi  |                                      |   |                                   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Adelaide Beryl Wainwright/Wife  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>203 Greenwood Avenue, Chestertown, MD 21620 |                                      |   |                                   |  |  |
|   | 20a. Method of Disposition<br>10 Burial 20 Cremation 30 Removal from State<br>40 Donation 50 Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Johns Cemetery |  | Date<br>4/5/99   |                                      | 20c. Location - City or Town, State<br>Bermuda          |                                   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>[Signature]  |  |  |  | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>130 Speer Road, Chestertown, MD 21620                 |                                      |   |                                   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Respiratory failure<br>Due to (or as a consequence of):<br>ARDS<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>CHF, @ Vent. Hypertrophy, Probable Metastatic Recurrence of Cancer, Hx Bladder & Prostate Cancer, COPD, A.F.b, @ BBB, Hx @ Hip fx Hx Anemia, DVT |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>10 Yes 20 No 30 Probably 40 Unknown<br>10 Yes 20 No                                |                                      |   |                                   | 24a. Was an autopsy performed?<br>10 Yes 20 No   |  |
|   | 25. Was case referred to medical examiner?<br>10 Yes 20 No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 60 Other (Specify) |                                      |   |                                   | 27. Manner of Death<br>10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending investigation 60 Could not be determined |  |
| 28a. Date of Injury (Month, Day, Year)  |   |  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>10 Yes 20 No |   | 28d. Describe how Injury occurred |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                      |   |                                   |  |  |
| 29a. Certifier (Check only one)<br>10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  | 29b. Signature and title of certifier<br>[Signature]   |  |                                      |   | 29c. License number<br>D 50996    |  |  |
| 29d. Date signed (Month, Day, Year)<br>4/1/99   |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Neil Stoddard 100 Brown St. Chestertown MD 21620 |  |                                      |   |                                   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999  |   |  |  | 32. Registrar's Signature<br>[Signature]   |  |                                      |   |                                   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #8, 04/06/99, T.M. Kent State of Maryland / Department of Health and Mental Hygiene  
Amended #20B, 3/31/99, C.W.C., Kent Co.

Certificate of Death

Reg. No.

99 12246

|   |  |  |  |   |  |                          |  |  |
|---|--|--|--|---|--|--------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Walter Edward Wickes   |  |  |   | 2. Date of Death<br>Month: March, Day: 27, Year: 1999  |                          | 3. Time of Death<br>12 noon  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>Chestertown Nursing & Rehabilitation   |  |  |   | 4b. City, Town, or Location of Death<br>Chestertown  |                          | 4c. County of Death<br>Kent  |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-16-9765   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>76 Yrs.  |                          | 8. Date of Birth (Month, Day, Year)<br>Oct. 14, 1922   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>Md.  |   | 10b. County<br>Kent  |                          | 10c. City, Town or Location<br>Chestertown   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |  |   | 10f. Zip Code<br>21620   |                          | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7th   |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Labor Foreman   |                          | 16b. Kind of Business/Industry<br>Construction   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charles Wickes  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Angelo Johnson  |                          |  |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br>Mrs. Theresa M. Wickes (Wife)  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6125 Quaker Neck Landing Rd. Chestertown, Md.   |                          |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Haddway Chapel Cem.  |                          | 20c. Location - City or Town, State<br>Chestertown, Md.  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Joseph O. Walley</i>   |  |  |   | 22. Name and Address of Facility<br>WALLEY Funeral Home Chestertown, Md.   |                          |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>Cardiopulmonary arrest</i><br>Due to (or as a consequence of):<br>f. <i>Atherosclerotic coronary artery disease</i><br>Due to (or as a consequence of):<br>g. <i>congestive heart failure</i><br>Due to (or as a consequence of):<br>h.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   | Approximate Interval Between Onset and Death<br>i. <i>1 minute</i><br>j. <i>months</i><br>k. <i>1-2 wks.</i>   |                          |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                          |  |  |
|   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                          |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                          |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 28d. Describe how injury occurred   |  |                          |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                          |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29c. License number<br>D51735   |  |                          |  |  |
| 29b. Signature and title of certifier<br><i>Frederick Delboy</i><br>MD  |  |  |  | 29d. Date signed (Month, Day, Year)<br>3/31/99  |  |                          |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Frederick Delboy M.D. 6602 Church Hill Rd. Chestertown, Md. 21620   |  |  |  | 31. Date filed (Month, Day, Year)<br>MAR 31 1999  |  |                          |  |  |
| 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |  |   |  |                          |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12247

|   |   |   |  |  |  |   |   |  |   |  |
|---|---|---|--|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ARTHUR ROLAND WOOD</b>                               |   |  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 31, 1999</b>             |  | 3. Time of Death<br><b>2:15 PM</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b> |   |  |  |  |   | 4b. City, Town, or Location of Death<br><b>CLINTON</b>                  |  | 4c. County of Death<br><b>PRINCE GEORGE'S</b>               |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-28-2830</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 16, 1918</b>            |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |
|   | Usual Residence of Decedent   |   |  |  |  |   |   |  |   |  |
| 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>PRINCE GEORGE'S</b>   |  | 10c. City, Town or Location<br><b>CLINTON</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>8911 DANGERFIELD PLACE</b>   |   |   |  | 10f. Zip Code<br><b>20735</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>   |   |  |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW-2</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FARMER</b>   |  |   | 16b. Kind of Business/Industry<br><b>AGRICULTURE</b>                    |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>ARTHUR H. WOOD</b>  |   |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>PEARL HAVENNER</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HELEN E. RISON - SISTER</b>  |   |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3880 TRANQUILITY PLACE, INDIAN HEAD, MD 20640</b> |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. BARNABAS CHURCH CEM., APRIL 6, 1999, TEMPLE HILLS, MD</b>   |  | 20c. Location - City or Town, State   |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>MARK G. BROHAWN M00053</b>  |   |   |  | 22. Name and Address of Facility<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156, WALDORF, MARYLAND 20604</b>  |  |   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dehydration</b><br>Due to (or as a consequence of):<br><b>Pneumonia</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>1 week</b><br><b>7 weeks</b> |   |   |  |  |  |   |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Myocardial Infarction</b>   |   |   |  |  |  |   |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |  |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |   |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |  |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>045365</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 1, 1999</b>   |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL G. SIDAROUS, MD., 11701 LIVINGSTON ROAD, SUITE #101, FT. WASHINGTON, MD 20744</b>  |   |   |  |  |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 02 1999</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |   |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12248

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN ESPY WILLIAMS

2. Date of Death

Month Day Year  
MARCH 17 99

3. Time of Death

15:54

4a. Facility Name (If not institution, give street and number)

UNIV. OF MARYLAND MEDICAL SYSTEM BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-34-1669

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 14, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

745 Danville Circle

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Insurance Salesman

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Espy (u/k)

18. Mother's Name (First, Middle, Maiden Surname)

Williams

18. Mother's Name (First, Middle, Maiden Surname)

Cordelia Beadenkopf White

19a. Informant's Name/Relationship (Type, Print)

Linda Williams/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

745 Danville Cir., Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion U.M. Chr. Cem.

Date

3-20-99

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Charles A. Emge Jr.

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)  
e. PULMONARY EMBOLUS

Approximate Interval Between Onset and Death

Unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeff Held M.D.

29c. License number

P12411

29d. Date signed (Month, Day, Year)

MARCH 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeff Held M.D. 22 South GREENE ST. BALTIMORE MD 21046

31. Date filed (Month, Day, Year)

MAR 22 1999

32. Registrar's Signature

B. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100

Ver 2.3 (4/10)

Ver 2.3 (4/10)

1028

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12249

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Catherine Rebecca Winterstein

2. Date of Death

March 25 1999

3. Time of Death

4:11 PM

4a. Facility Name (If not institution, give street and number)

Madonna Heritage

4b. City, Town, or Location of Death

Jarrettsville

4c. County of Death

Harford

5. Social Security Number

212-40-5805

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 24, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2009 Waverly Drive

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner / Operator

16b. Kind of Business/Industry

Private Transportation

17. Father's Name (First, Middle, Last)

George Henry Burton

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Elizabeth Grammer

19a. Informant's Name/Relationship (Type, Print)

Carolyn W. Fields/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2009 Waverly Dr., Bel Air, MD 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

3-29-99

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
50 W. Broadway Street, Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Wiedefeld MD

29c. License number

P33011

29d. Date signed (Month, Day, Year)

3/26/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert Wiedefeld 3346 Paper Mill RD Phoenix MD 21131

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

B. Spahr

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

2001 2 3 11AM

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12250

|  |  |   |  |   |  |  |   |   |  |
|--|--|---|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Stephen Henry Wilson</b>  |   |  |   | 2. Date of Death<br>Month Day Year<br><b>March 22 1999</b> |  | 3. Time of Death<br><b>12:03 am</b>                         |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins University Bayview Medical Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-46-2478</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 12, 1947</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Harford</b>                              |  | 10c. City, Town or Location<br><b>Bel Air</b>               |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>7 Roland Place</b>   |  | 10f. Zip Code<br><b>21014</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                    |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>   |  | 16b. Kind of Business/Industry<br><b>Laundromat</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>John William Wilson</b>                                      |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Clara Geneva Roberts</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John W. Wilson/ Father</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 Roland Pl., Bel Air, MD 21014</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Highland Presbyterian Cem</b> |   | 20c. Location - City or Town, State<br><b>3-24-99 Street, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Aspiration</b><br>Dua to (or as a consequence of):<br><br>b. <b>left distal tibia fib fracture</b><br>Dua to (or as a consequence of):<br><br>c. <b>Renal Osteodystrophy</b><br>Dua to (or as a consequence of):<br><br>d. <b>End stage renal disease on Hemodialysis</b> |  | Approximate Interval Between Onset and Death   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                               |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>96120</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 22, 1999</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William Tsong 4940 Eastern Ave, Baltimore MD 21224</b>  |  | 31. Date filed (Month, Day, Year)<br><b>2 5 1999</b>  |  | 32. Registrar's Signature<br>   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



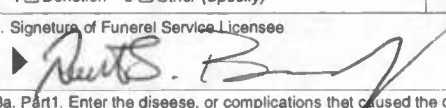
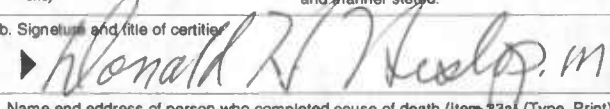
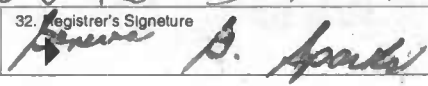
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12251

|  |  |                                    |   |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
|--|--|------------------------------------|---|--|---|--|--|---|---|----|----------------------|--|----|------------------------------|--------------|----|--|--|----|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William Howard Wray</b>                   |                                    |   |  | 2. Date of Death<br>Month Day Year<br><b>March 27, 1999</b>   |  | 3. Time of Death<br><b>7:30am</b>  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>1305 North Road</b> |                                    |   |  | 4b. City, Town, or Location of Death<br><b>Severna Park</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>287-12-9384</b>  |                                    | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 19, 1921</b>                                     |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>                                  |                                    |   |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| Usual Residence of Decedent  |  |                                    |   |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b> |   | 10c. City, Town or Location<br><b>Severna Park</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 10e. Street and Number<br><b>1305 North Road</b>   |  |                                    |   | 10f. Zip Code<br><b>21146</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>   |  |                                    |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Research Analyst</b> |   |  | 16b. Kind of Business/Industry<br><b>National Security Agency</b>                              |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Gordon Wray</b>  |  |                                    |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alta Laytart</b>  |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Wray / wife</b>  |  |                                    |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1305 North Road, Severna Park, MD 21146</b>   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                    |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                     |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                                    |   |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>  |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |                                    |   |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Renal Failure</b></td> <td>Approximate Interval Between Onset and Death<br/><b>3 mo.</b></td> </tr> <tr> <td>b.</td> <td><b>Renal Artery Stenoses</b></td> <td><b>3 mo.</b></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |  |                                    |   |  |   |  |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Renal Failure</b> | Approximate Interval Between Onset and Death<br><b>3 mo.</b> | b. | <b>Renal Artery Stenoses</b> | <b>3 mo.</b> | c. |  |  | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.   | <b>Renal Failure</b>               | Approximate Interval Between Onset and Death<br><b>3 mo.</b>  |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
|  | b.   | <b>Renal Artery Stenoses</b>       | <b>3 mo.</b>  |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
|  | c.   |                                    |   |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
|  | d.   |                                    |   |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                    |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
|  |  |                                    |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
|  |  |                                    |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                    | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |                                    | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
|  |  |                                    | 28d. Describe how injury occurred   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
|  |  |                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |                                    | 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br><b>DO8293</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/27/99</b> |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>31 Robinson Rd Severna Park, MD 21146 DONALD HYSLOP MD</b>  |  |                                    |   |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 02 1999</b>  |  |                                    | 32. Registrar's Signature<br>   |  |   |  |  |   |   |    |                      |  |    |                              |              |    |  |  |    |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12252

|  |  |                                    |  |  |   |  |   |  |
|--|--|------------------------------------|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Clarence Edward Watkins</b>                     |                                    |  |  | 2. Date of Death<br>Month <b>MAR</b> Day <b>25</b> Year <b>99</b> |  | 3. Time of Death<br><b>1907</b>                             |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Gen Hosp</b> |                                    |  |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>          |  | 4c. County of Death<br><b>AA</b>                            |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-05-2185</b>  |                                    | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   | If Under 1 Year<br>Months Days                                    | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>april 12 1921</b> | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                      |
|  | Usual Residence of Decedent  |                                    |  | 10c. City, Town or Location<br><b>EDGEWATER</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 10e. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b> |  | 10f. Zip Code<br><b>21037</b>  |   |  | 10g. Citizen of What Country?<br><b>US</b>                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                                    |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944-46</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>          |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+) <b>0</b>  |  |                                    |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HEAVY EQUIPMENT OPERATOR</b>   |   |  | 16b. Kind of Business/Industry<br><b>BGE</b>                |  |
| 17. Father's Name (First, Middle, Last)<br><b>CLARENCE WATKINS</b>   |  |                                    |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET TALBOT</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HEKEN WATKINS (WIFE)</b>  |  |                                    |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RT. 2 BOX 104 DORSEY DR. EDGEWATER, MD. 21037</b>  |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                    |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERAN CEME.</b>  |   | 20c. Location - City or Town, State<br><b>4/1/99 CROWNSVILLE, MD.</b>  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Larry H. Reese</b>   |  |                                    |  | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>Acute Myocardial Insufficiency Minutes</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Arteriosclerotic Heart Disease</b><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____<br/>Due to (or as a consequence of):</p> </div> </div> |  |                                    |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                    |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|  |  |                                    |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |  |                                    |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |                                    |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |                                    |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|  |  |                                    |  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |
|  |  |                                    |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |                                    |  | 29b. Signature and title of certifier<br><b>William P. Jones, MD Deputy</b>  |   | 29c. License number<br><b>DO6054</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>                            |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>William P. Jones, MD 695 America # 21035</b>  |  |                                    |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |  |                                    |  | 32. Registrar's Signature<br><b>Arnell B. Sparks</b>   |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12253

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ALFRED E. WILLIAMS JR.</b>                            |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 25 1999</b> |  | 3. Time of Death<br><b>0532</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-48-1657</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 31 1946</b>                                   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ANNE ARUNDEL</b>                         |  | 10c. City, Town or Location<br><b>ANNAPOLIS</b>   |  |
| Usual Residence of Decedent  |  |  |   |  |  |  |   |  |
| 10a. State<br><b>MARYLAND</b>  |  |  | 10b. County<br><b>ANNE ARUNDEL</b>  |  |  | 10c. City, Town or Location<br><b>ANNAPOLIS</b>  |   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  | 10e. Street and Number<br><b>44 LAFAYETTE AVENUE</b>  |  |  | 10f. Zip Code<br><b>21401</b>  |   |  |
| 10g. Citizen of What Country?<br><b>US</b>   |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1964-67</b> |   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>BLACK</b>  |  |  | 14. Raca - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>0</b>                           |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SUPERVISOR TECHNICIAN</b>  |  |  | 16b. Kind of Business/Industry<br><b>FORD MOTOR CORP.</b>   |  |  | 17. Father's Name (First, Middle, Last)<br><b>ALFRED E. WILLIAMS SR.</b>   |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CLEMENTINE SMITH</b>   |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>CLEMENTINE WILLIAMS (MOTHER)</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>44 LAFAYETTE AVE. ANNAPOLIS, MD. 21401</b>                   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERAN CEME.</b>   |  |  | 20c. Date<br><b>4/1/99</b>   |   |  |
| 20d. Location - City or Town, State<br><b>CROWNSVILLE, MD.</b>   |  |  | 21. Signature of Funeral Service Licensee<br><i>Larry G. Reese</i>  |  |  | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |  |  |  |   |  |
| Immediate Cause (Final disease or condition resulting in death)  |  |  |   |  |  |  |   |  |
| a. <i>septicemia</i> Due to (or as a consequence of): <i>3d</i>  |  |  |   |  |  |  |   |  |
| b. <i>Intestinal / Ileus</i> Due to (or as a consequence of): <i>3d</i>  |  |  |   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |   |  |  |  |   |  |
| c. Due to (or as a consequence of):  |  |  |   |  |  |  |   |  |
| d. Due to (or as a consequence of):  |  |  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |  |   |  |
| <i>End stage renal disease, restrictive lung disease, exogenous obesity</i>  |  |  |   |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                            |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28d. Describe how Injury occurred  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Gregory A. Mitchell MD</i>   |  |  | 29c. License number<br><b>D14758</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>3-29-99</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Gregory A. Mitchell 621 Ridge Ave ANNAPOLIS MD 21401</i>  |  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |  |  | 32. Registrar's Signature<br><i>James B. Smith</i>  |  |  |  |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,







Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 202-555-2025.

HELEN WALTERS (213-22-3996)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Helen Louise Walters</b>  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>21</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>3:05 a.m.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b>   |  |
| 5. Social Security Number<br><b>213-22-3996</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>May 18, 1924</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Oldtown</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>18411 Lemuel Drive SE</b>   |  | 10f. Zip Code<br><b>21555</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b><br>Elementary/Secondary (0-12) Collage (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>former employee</b>   |  | 16b. Kind of Business/Industry<br><b>Textile</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Russell Crabtree</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie (Alderton)</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard Walters husband</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18411 Lemuel Drive SE; Oldtown, MD 21555</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oldtown Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>3/23/ Oldtown, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Nicholas J. Scarpelli</i>  |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home P.A.<br/>Cumberland, Maryland 21502</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |  | a. <b>PNEUMONIA</b>   |  | Approximate Interval Between Onset and Death<br><b>ONE WEEK</b>  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |
| b. Due to (or as a consequence of):  |  |   |  |  |  |
| c. Due to (or as a consequence of):  |  |   |  |  |  |
| d. Due to (or as a consequence of):  |  |   |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>5-Q SYNDROME</b>   |  |   |  |  |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Terry E. Williams M.D.</i>   |  | 29c. License number<br><b>D16041</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 23, 1999</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Terry E, Williams M.D.; Memorial Hospital Med Bldg Cumberland MD 21502</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 24 1999</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

3. Time of Death  
0100 amPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edna Mae Wilt

2. Date of Death  
Month Day Year

March 22, 1999

4c. County of Death

Allegany

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

5. Social Security Number

214-30-9812

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Apr 9, 1926

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Grantsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

96 Miner Road

10f. Zip Code

21536

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6 th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Gorman Broadwater

18. Mother's Name (First, Middle, Maiden Surname)

Pearl (Broadwater)

19a. Informant's Name/Relationship (Type, Print)

Kenneth E. Wilt/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

117 Petenbrink Rd., Garrett, PA 15542

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bittinger Cemetery, Mar. 25, 1999

Date

20c. Location - City or Town, State

Bittinger, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Newman Funeral Homes, P.A., P.O. Box 275  
179 Miller St., Grantsville, MD 21536

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION 2 DAYS

Due to (or as a consequence of):

b. MULTIPLE RIB FRACTURE AND

Due to (or as a consequence of):

c. PNEUMO THORAX 4 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CA OF THE LUNG

RESPIRATORY FAILURE

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24951

29d. Date signed (Month, Day, Year)

March 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chang Oh, M.D. 48 Tarn Terrace Frostburg, MD 21532

31. Date filed (Month, Day, Year)

MAR 24 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



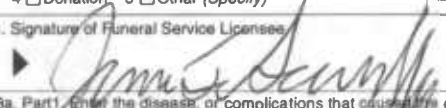


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

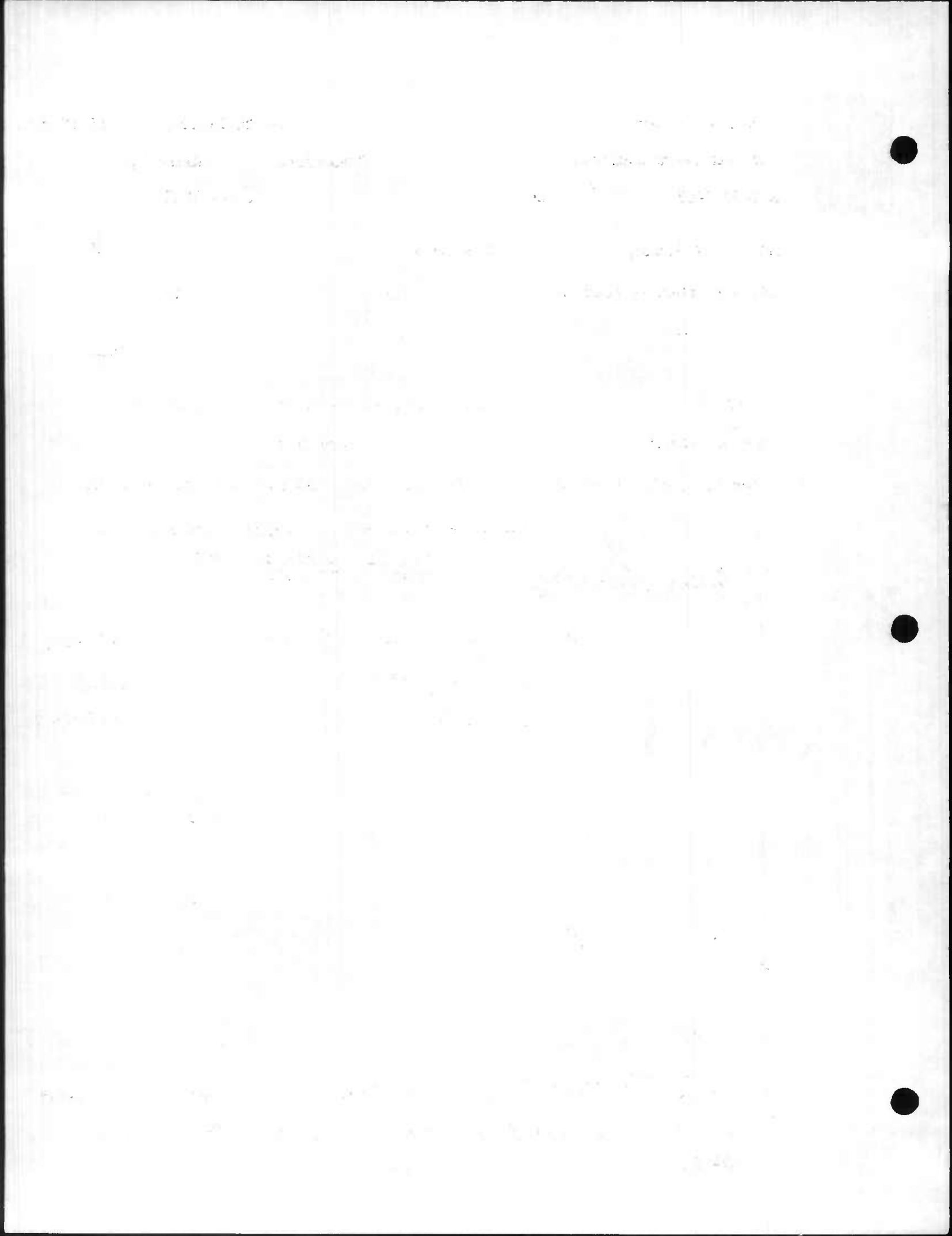
Reg. No.

99 12256

|   |  |  |  |  |   |  |   |   |  |  |
|---|--|--|--|--|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Helen Winkler</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 18, 1999</b>   |  |   |   | 3. Time of Death<br><b>11:15 P.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  |   |   | 4c. County of Death<br><b>Allegany</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-80-5405</b>  |  | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jul 12, 1918</b>                                  |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|   | Usual Residence of Decedent  |  |  |  |   |  |   |   |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Allegany</b>   |  | 10c. City, Town or Location<br><b>Cresaptown</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>14300 Winchester Road SW</b>  |  |  |  | 10f. Zip Code<br><b>21502</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary <input type="checkbox"/> Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Former Co-Owner Cuffy's Corner</b> |  |   |  | 16b. Kind of Business/Industry<br><b>General Store</b>                                      |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Bernard Cecil</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary (Hite)</b>   |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>James R. Winkler-husband</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14300 Winchester Road SW Cresaptown MD 21502</b>  |  |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park</b>  |  | Data<br><b>03/22</b>  |  | 20c. Location - City or Town, State<br><b>Cumberland MD</b>                                 |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home, P.A.<br/>Cumberland MD 21502</b>   |  |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><b>c. Dementia</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  |   |  |   |   |  |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>Approximate Interval Between Onset and Death<br><b>unknown</b><br><b>unknown</b><br><b>unknown</b>  |  |  |  |   |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how Injury occurred  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29c. License number<br><b>D040693</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 23, 1999</b>                                |   |  |  |
|   | 29b. Signature and title of certifier<br>   |  |  |  | 30. Name and address of person who completed causa of death (Item 23e) (Type, Print)<br><b>Samir A. Elian, M.D. 909-B Seton Drive Cumberland MD 21502</b>   |  |   |   |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAR 23 1999</b>  |  |  |  | 32. Registrar's Signature<br>  |  |   |   |  |  |

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12257**  
**Certificate of Death**

Reg. No.

|   |   |   |   |   |  |  |  |  |
|---|---|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Florence Julia Weber</b>   |   |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>28</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>7:30 a.m.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Cumberland Nursing Home</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |  | 4c. County of Death<br><b>Allegheny</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-22-5467</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>March 23 1905</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|   | Usual Residence of Decedent   |   |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Allegheny</b>   | 10c. City, Town or Location<br><b>Cumberland</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br><b>512 Winifred Road</b>  |   |   | 10f. Zip Code<br><b>21502</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>0</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |   | 16b. Kind of Business/Industry<br><b>Home</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Wattenschaidt</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minnie Marks</b>  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Marion Tibbetts daughter</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15613 Winslow Street Cumberland, MD 21502</b> |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Frostburg Memorial Park</b>  |   | Date<br><b>March 31 1999</b>   | 20c. Location - City or Town, State<br><b>Frostburg MD</b>                                     |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>James E. McKenzie</b>   |   |   | 22. Name and Address of Facility<br><b>Eichhorn-McKenzie Funeral Home P.A.<br/>Lonaconing, MD</b>   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div> <p>immediata Causa (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div> <p>a. <b>Aspiration pneumonia</b><br/>Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div> <p>Approximate Interval Between Onset and Death<br/><b>2 days.</b></p> </div> </div> |   |   |   |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>OBS</b><br><b>old age</b>  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Pete Schley</b>   |   | 29c. License number<br><b>DO 4981</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1999</b>                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>P. H. ALMOS 302 Schley St. Cumberland, Md 21502</b>  |   |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





99 12258

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Loretta White</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>MARCH</u> DAY <u>23</u> YEAR <u>1999</u>   |  | 3. TIME OF DEATH<br><u>4:15 P M</u>   |   |
| 4. SOCIAL SECURITY NUMBER<br><u>217-12-4492</u>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><u>79</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>Sept 4, 1919</u>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Peninsula Regional Medical Center</u>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Salisbury</u>   |  | 9c. COUNTY OF DEATH<br><u>Wicomico</u>  |   |
| 10a. STATE<br><u>MD</u>  |  | 10b. COUNTY<br><u>Wicomico</u>   |  | 10c. CITY, TOWN OR LOCATION<br><u>Salisbury</u>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |   |
| 10e. STREET AND NUMBER<br><u>1214 Flamingo Dr.</u>   |  |  |  | 10f. ZIP CODE<br><u>21801</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>21801</u>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>Black</u>                               |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><u>8th</u>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Laborer</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Poultry</u>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>John Jones, Sr.</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Betty Waters</u>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Gloria Wessels/daughter</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1214 Flamingo Dr., Salisbury, MD 21801</u>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Grace UMC Cemetery</u>   |  | DATE<br><u>3/27</u>   |  | 20c. LOCATION — City or Town, State<br><u>Venton, MD</u>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Lewis N. Watson Funeral Home</u><br><u>1618 West Rd., Salisbury, MD 21801</u>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <u>Pulmonary edema / Pneumonia</u>  |  |   |  |   | Approximate Interval Between Onset and Death<br><u>3 Mon/ks</u> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <u>atherosclerotic cardiovascular Disease.</u>  |  |   |  |   | <u>&gt; 1yr</u>   |
|  |  | c. <u>Chronic atrial fibrillation.</u>   |  |   |  |   | <u>&gt; 1yr</u>   |
|  |  | d. <u>Cerebrovascular accident / Dysphagia</u>   |  |   |  |   | <u>&gt; 1yr</u>   |
|  |  |  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>DR. USHA NATESAN</u>   |  |  |  | 29c. LICENSE NUMBER<br><u>D051389</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>3/25/99</u>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>DR. USHA NATESAN, M.D., MANOKIN MANOR NURSING HOME, PRINCESSANNE MD 21853</u>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><u>MAR 26 1999</u>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-12259

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Andrew Whitehead

2. Date of Death  
Month Day Year

March 12 1999

3. Time of Death

2:50 P.M.

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

214-30-0419

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Jan. 16, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9215 Grant Avenue

10f. Zip Code

20723

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If ☒ Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
Grade 10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Service Mechanic

16b. Kind of Business/Industry

U.S. Government  
( U.S.D.A. )

17. Father's Name (First, Middle, Last)

Leonard Whitehead

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Lammers

19a. Informant's Name/Relationship (Type, Print)

Jane Whitehead / spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9215 Grant Avenue Laurel, Maryland 20723

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

3/16/99

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Gry S. Ky

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Avenue Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 / yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael Fleckenstein

29c. License number

036716

29d. Date signed (Month, Day, Year)

3/12/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Kunkat, M.D. 8317 Cherry Lane, Laurel, MD 20707

31. Date filed (Month, Day, Year)

MAR 16 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

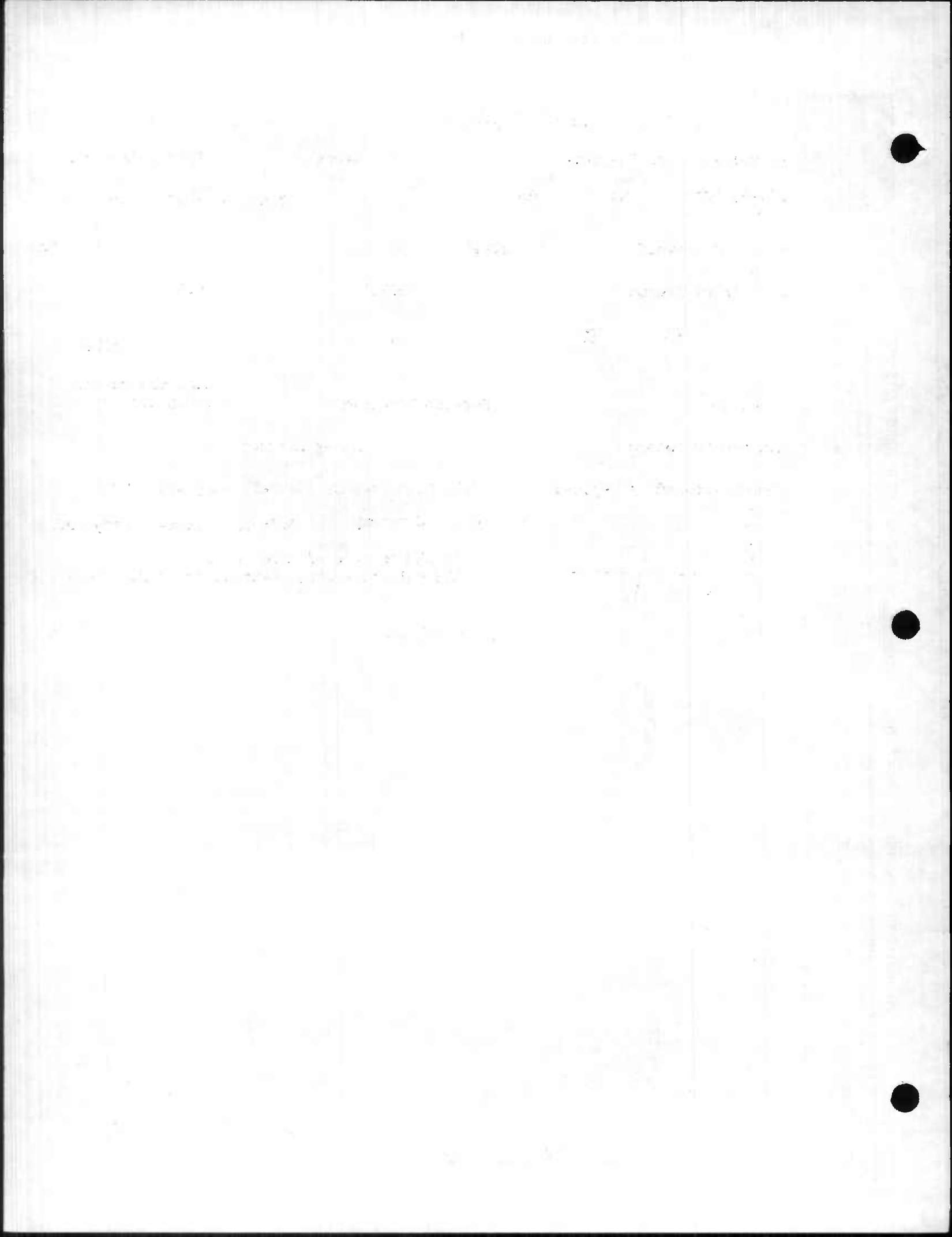
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12260

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert L. WATSON, SR

2. Date of Death

March 27 1999

Day

Year

3. Time of Death

9:20 pm

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

220-20-5011

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 5, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12934 Folly Quarter Road

10f. Zip Code

21042

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1947-55

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Retail Food Store

17. Father's Name (First, Middle, Last)

William R. Watson

18. Mother's Name (First, Middle, Maiden Summa)

Rose A. Gischel

19a. Informant's Name/Relationship (Type, Print)

Barbara A. Watson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12934 Folly Quarter Road Ellicott City, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lakeview Memorial Park

Date

3-30-99

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

► Sean A. Collins-Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis/Cardiogenic Shock

Due to (or as a consequence of):

b.

Bilateral pneumonia

Due to (or as a consequence of):

c.

end stage lymphoma.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, prostate cancer, CHF

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► [Signature] MD

29c. License number

D50973

29d. Date signed (Month, Day, Year)

March 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACOB CHERIAN Patuxent Med Group, Two Knoll North Dr, Columbia Md

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

► [Signature]

21045

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

March

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12261

## Certificate of Death

Reg. No.

|                                     |  |  |   |  |   |  |   |  |  |  |
|-------------------------------------|--|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Peggy Lou Young  |  |   |  | 2. Date of Death<br>Month Day Year<br>April 2, 1999   |  |   |  | 3. Time of Death<br>0705   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br>107 Pine Street (Residence)  |  |   |  | 4b. City, Town, or Location of Death<br>Chestertown   |  |   |  | 4c. County of Death<br>Kent  |  |
| Funeral<br>Director                 | 5. Social Security Number<br>189-20-9606   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>74 Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  |
|                                     | 8. Date of Birth (Month, Day, Year)<br>January 8, 1925   |  | 9. Birthplace (State or Foreign Country)<br>Uniontown, PA   |  | 10a. State<br>Maryland  |  | 10b. County<br>Kent   |  | 10c. City, Town or Location<br>Chestertown   |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>107 Pine Street   |  | 10f. Zip Code<br>21620  |  | 10g. Citizen of What Country?<br>USA  |  | 10h. Usual Residence of Decedent   |  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 4   |  |
|                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>RN-Nurse  |  | 16b. Kind of Business/Industry<br>Health Care   |  | 17. Father's Name (First, Middle, Last)<br>H. Edward Laughead   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emma Fields  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Patricia Gruber/Daughter   |  |
|                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>201 Mapel Avenue, Chestertown, Maryland 21620   |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Cremation Center, LLC 4/2/99   |  | 20c. Location - City or Town, State<br>Stevensville, Maryland   |  | 21. Signature of Funeral Service Licensee  |  |
|                                     | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>130 Speer Road, Chestertown, MD 21620   |  | 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>POLYCYTHEMIA VERA  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |
|                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
|                                     | 29b. Signature and title of certifier<br>John C. Seymour   |  | 29c. License number<br>D-13824  |  | 29d. Date signed (Month, Day, Year)<br>4-2-99   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>John C. Seymour, 122 Speer Road, Suite 5, Chestertown, Maryland 21620 |  | 31. Date filed (Month, Day, Year)<br>APR 02 1999   |  |
|                                     | 32. Registrar's Signature<br>Benita B. Sparks  |  |   |  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12262

|   |   |   |  |   |   |   |   |  |  |
|---|---|---|--|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Richard Dale Yonker</b>                                  |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>16</b> Year <b>1999</b> |   | 3. Time of Death<br><b>9:10 AM</b>                          |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Columbia</b>               |   | 4c. County of Death<br><b>Howard</b>                        |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>275 28 1325</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>August 3 1933</b> |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>   |   | 10. State<br><b>Ga</b>   |   | 10b. County<br><b>De Kalb</b>   |   | 10c. City, Town or Location<br><b>Tucker</b>                |  |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10a. Street and Number<br><b>3938 Laura Ct.</b>   |   | 10f. Zip Code<br><b>30084</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1950-</b><br>If Yes, Give Year or Dates: <b>1954</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>1</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Person</b>  |  | 16b. Kind of Business/Industry<br><b>Commercial Sales</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Unknown Yonker</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown Ebbert</b> |  |
| 19a. Informant's Name/Relationship (Type, Print) <b>Wife</b><br><b>Lady C.R. McAbee Yonker (Former)</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3938 Laura Ct. Tucker Ga. 30084</b>   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>George Washington Univ. Med. Ctr</b>                               |   | 20c. Location - City or Town, State<br><b>Washington DC</b>                |  |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Columbia Mortuary Services</b><br><b>PO Box 58007 Washington DC 20037</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Ventricular Fibrillation</b><br>Due to (or as a consequence of):<br><b>Hypoxic Encephalopathy</b><br><br><b>b. Hypoxic Encephalopathy</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |   | Approximate Interval Between Onset and Death<br><b>5 Days</b><br><b>5 Days</b>  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No         |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br> <b>ASYMD</b>   |  | 29c. License number<br><b>D 39629</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 18 1999</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ALEXANDER SY MD</b>  |   | 31. Data filed (Month, Day, Year)<br><b>MAR 18 1999</b>   |  | 32. Registrar's Signature<br>   |   | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>10724 Little Patuxent Parkway Columbia Md. 21044</b> |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12263

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOUIE JOHN ZAHRA

2. Date of Death

March 26, 1999

3. Time of Death

6:20 pm

4a. Facility Name (If not institution, give street and number)

Hebrew Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

267-09-7851

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 7, 1919

9. Birthplace (State or Foreign Country)

FL

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15210 Elkridge Way # 1-D

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 42-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Sales

17. Father's Name (First, Middle, Last)

Mahana Zahra

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Musa

19a. Informant's Name/Relationship (Type, Print)

Michael J. Zahra / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4834 Sweetbitch Drive, Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Quantico National Cemet. 3-31-99 Quantico, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Collins Funeral Home  
500 University Blvd, W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. CEREBROVASCULAR ACCIDENT

2 MONTHS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. HYPERTENSIVE CEREBROVASCULAR DISEASE

YEARS

Due to (or as a consequence of):

c. HYPERTENSION

YEARS

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN LIPSON 4021 MONTROSE RD, ROCKVILLE

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

Steven B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 99 12264

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |  |  |  |  |  |
|---|---|--|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MILDRED W. ZUERLEIN</b>  |  |   |  | 2. Date of Death<br>Month <b>03</b> Day <b>28</b> Year <b>99</b>  |  |  |  | 3. Time of Death<br><b>4:30 pm</b>   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Eldercare - Layhill Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  |  |  | 4c. County of Death<br><b>Montgomery</b>   |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>336-22-1231</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>08-15-27</b> |  | 9. Birthplace (State or Foreign Country)<br><b>IL</b>  |  |  |  |
|   | Usual Residence of Decedent   |  |   |  | 10a. State<br><b>MD</b>   |  |  |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Rockville</b>  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>4317 Joplin Drive</b>  |  |   |  | 10f. Zip Code<br><b>20853</b>   |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harry Weber</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gertrude Wankel</b>   |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kenneth H. Zuerlein /Husband</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4317 Joplin Drive, Rockville, MD 20853</b>  |  |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  |  |  | Date<br><b>4-1-99</b>  |  | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>                                |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Collins Funeral Home</b><br><b>500 University Blvd West, Silver Spring, MD</b>   |  |  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. {</b><br><b>c. {</b><br><b>d. {</b> |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>4 weeks</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Dementia</b>   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |  |  |
|   |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                        |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>D35045</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 28, 1999</b>                                   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Philip Henjum, MD, 3416 Olandwood Court #204, Olney, MD 20832</b>  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |  |  |  | 32. Registrar's Signature<br>                                  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar



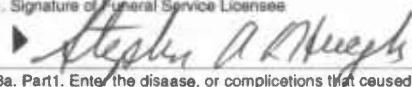

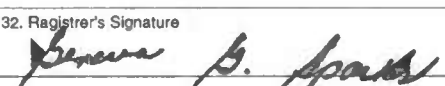
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12265

|   |  |   |  |  |   |  |  |   |  |
|---|--|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John Francis Zerhusen</b>                           |   |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>26</b> Year <b>1999</b> |  | 3. Time of Death<br><b>2326</b>                            |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Fallston General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Fallston</b>               |  | 4c. County of Death<br><b>Harford</b>                      |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-07-1286</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 7, 1920</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                       |  |
|   | Usual Residence of Decedent  |   |  |  |   |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Edgewood</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| 10e. Street and Number<br><b>2015 Hanson Road</b>   |  |   |  | 10f. Zip Code<br><b>21040</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | Collage (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Installer and Lineman</b>  |   | 16b. Kind of Business/Industry<br><b>U. S. Government</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Peter Adam Zerhusen</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara Mary Ruck</b>  |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Vivian E. Zerhusen/Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2015 Hanson Road, Edgewood, MD 21040</b>   |   |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park</b>   |  | Date<br><b>3/30/99</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, MD 21009</b>  |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Asystole</b><br><b>b. End stage coronary artery disease</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>5 minutes</b><br><b>10 yrs</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe chronic Respiratory disease and Respiratory failure.</b><br><b>Diabetes Mellitus</b>  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                         |  |   |  |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br> <b>Attending</b>   |  | 29c. License number<br><b>D-16444</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 27th 1999</b>  |   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  | 32. Registrar's Signature<br>   |  |  |   |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1941

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MYRL THOMAS ZIMMERS

2. Date of Death  
Month Day Year

March 28, 1999

3. Time of Death

4:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

234-42-9724

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

FEB 17, 1932

9. Birthplace (State or Foreign Country)

W. VA.

Usual Residence of Decedent

10a. State

W. VA.

10b. County

MINERAL

10c. City, Town or Location

RIDGELEY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RFD#1 BOX#257

10f. Zip Code

26753

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: KOREA

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

KELLY SPRINGFIELD TIRE CO

16b. Kind of Business/Industry

TIRES MANUF.

17. Father's Name (First, Middle, Last)

MYRL M. ZIMMERS

18. Mother's Name (First, Middle, Maiden Surname)

MADELINE E. CANNON

19a. Informant's Name/Relationship (Type, Print)

BARBARA CLARK

DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RFD#1 BOX#73 WILEY FORD W. VA. 26767

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SUNSET CEMETERY MARCH 30 1999

Date

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cirrhosis of liver

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dale L. Merritt

29c. License number

D36766

29d. Date signed (Month, Day, Year)

March 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIK POONAI, M.D., 920 National Highway LaVale MD 21502

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

13

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene 99 12267

## Certificate of Death

Reg. No.

|  |  |                           |  |  |   |   |   |   |                                   |
|--|--|---------------------------|--|--|---|---|---|---|-----------------------------------|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><u>AL Andrews</u>  |                           |  |  | 2. Date of Death<br>Month <u>April</u> Day <u>11</u> Year <u>1999</u>   |   | 3. Time of Death<br><u>9:10 pm</u>                                      |   |                                   |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Maryland General Hospital</u>   |                           |  |  | 4b. City, Town, or Location of Death<br><u>Baltimore City</u>   |   | 4c. County of Death   |   |                                   |
| Funeral<br>Director  | 5. Social Security Number<br><u>116-03-7704</u>  |                           | 6. Sex<br><u>1</u> M <u>2</u> F  | 7. Age (In yrs. last birthday)<br><u>83</u> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Birth<br>(Month, Day, Year)<br><u>10-15-15</u>               | 9. Birthplace (State or Foreign Country)<br><u>North Carolina</u> |                                   |
|  | Usual Residence of Decedent  |                           |  |  |   |   |   |   |                                   |
| To Be Completed by Funeral Director                                  | 10a. State<br><u>Md.</u>   | 10b. County<br><u>NIA</u> | 10c. City, Town or Location<br><u>Baltimore</u>  |  |   | 10d. Inside City Limits<br><u>1</u> Yes <u>2</u> No |   |   |                                   |
|  | 10e. Street and Number<br><u>2400 East Oliver Street</u>   |                           |  | 10f. Zip Code<br><u>21213</u>                    |   | 10g. Citizen of What Country?<br><u>USA</u>         |   |   |                                   |
|  | 11. Marital Status<br><u>2</u> Married<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> Yes <u>2</u> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> Yes <u>2</u> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u> |   |                                   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>3rd</u> College (1-4or 5+)   |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Cook</u>   |  | 16b. Kind of Business/Industry<br><u>Penn Rail Road</u>   |   |   |   |                                   |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><u>Alayes Andrews</u>   |                           |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>UKN.</u>  |   |   |   |                                   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Alonzo John Andrews - Son</u>   |                           |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2010 Hillenwood Rd. Balto. Md. 21239</u>      |   |   |   |                                   |
|  | 20a. Method of Disposition<br><u>1</u> Burial <u>2</u> <input checked="" type="checkbox"/> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify)   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Metro Crematory</u>   |  | 20c. Location - City or Town, State<br><u>4-13-99 Baltimore, Maryland</u>   |   |   |   |                                   |
|  | 21. Signature of Funeral Service Licensee<br><u>Jeff Miller</u>  |                           | 22. Name and Address of Facility<br><u>Jeff Miller P.C. Funeral Home &amp; Services</u><br><u>1639 N. Broadway Balto. Md. 21213</u>  |  |   |   |   |   |                                   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Sepsis</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |                           |  |  |   |   |   | Approximate interval Between Onset and Death                      |                                   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Decubital Ulcer, Emphysema</u>  |                           |  |  |   |   |   |   |                                   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown  |                           |  |  |   |   |   |   |                                   |
|  | 24a. Was an autopsy performed?<br><u>1</u> Yes <u>2</u> No 24b. Were autopsy findings available prior to completion of cause of death?<br><u>1</u> Yes <u>2</u> No   |                           |  |  |   |   |   |   |                                   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><u>1</u> Yes <u>2</u> No   |                           | 26. Place of Death (Check only one)<br>Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) |  |   |   |   |   |                                   |
|  | 27. Manner of Death<br><u>1</u> Natural <u>5</u> Pending investigation<br><u>2</u> Accident <u>6</u> Could not be determined<br><u>3</u> Suicide <u>4</u> Homicide   |                           | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br><u>1</u> Yes <u>2</u> No                        |   | 28d. Describe how injury occurred |
|  | 29a. Certifier (Check only one)<br><u>1</u> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |                           | 29b. Signature and title of certifier<br><u>Swaminathan M.D.</u>   |  | 29c. License number<br><u>712677</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>4/11/99</u>                   |   |                                   |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>JAWAHAR SWAMINATHAN, M.D. 90 Maryland General Hospital</u>  |                           |  |  |   |   |   |   |                                   |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><u>APR 14 1999</u>  |                           |  |  | 32. Registrar's Signature<br><u>B. Sparks</u>   |   |   |   |                                   |



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12268

|   |  |  |   |                                |  |  |  |   |
|---|--|--|---|--------------------------------|--|--|--|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Deidria Brown</b>   |  |   |                                | 2. Date of Death<br>Month Day Year<br><b>April 10, 1999</b>  |  | 3. Time of Death<br><b>17:54 PM</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Memorial Hospital</b>   |  |   |                                | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>NA</b>   |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-78-6249</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>3-28-1960</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Md</b> |
|   | Usual Residence of Decedent  |  |   |                                |  |  |  |   |
| To Be Completed by Funeral Director           | 10e. State<br><b>Md</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Lochearn</b>  |                                |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
|   | 10e. Street and Number<br><b>3421 Fairview Road</b>  |  |   | 10f. Zip Code<br><b>21207</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |  |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>NA</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Unk</b>   |                                |  | 16b. Kind of Business/Industry <b>Unk</b>  |  |   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Carroll L. Brown</b>   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ernestine Spellman</b>   |  |  |   |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Ernestine Blanks - Mother</b>   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3421 Fairview Road Baltimore, Md 21207</b>   |  |  |   |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |                                | Date<br><b>4-16-99</b>   |  | 20c. Location - City or Town, State<br><b>Woodlawn, Md</b>   |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Syrette K. Jones</b>   |  |   |                                | 22. Name and Address of Facility<br><b>March F. H. West</b><br><b>4300 Wabash Avenue Balto, Md 21215</b>   |  |  |   |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |                                |  |  | Approximate Interval Between Onset and Death   |   |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Severe Streptococcal Sepsis</b><br>Due to (or as a consequence of):   |  |   |                                |  |  | <b>5 days</b>  |   |
|   | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. <b>DIC</b><br>Due to (or as a consequence of):   |  |   |                                |  |  | <b>1 day</b>   |   |
|   | c. <b>Acute Renal Failure</b><br>Due to (or as a consequence of):  |  |   |                                |  |  | <b>2 days</b>  |   |
| To Be Completed by Physician/Medical Examiner | d. <b>ARDS</b><br>Due to (or as a consequence of):   |  |   |                                |  |  | <b>4 days</b>  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Intractable Metabolic Acidosis</b>  |  |   |                                |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |  |   |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |                                |  |  |  |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |                                |  |  |  |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |  |  |  |   |
| State Registrar                               | 29b. Signature and title of certifier<br><b>Hanan I. KHALIL, MD</b>  |  |   |                                | 29c. License number<br><b>P12570</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>04/10/1999</b>   |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>HANAN I. KHALIL, Union Memorial Hospital</b>  |  |   |                                |  |  |  |   |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |  | 32. Registrar's Signature<br><b>Bruce B. Sparks</b>   |                                |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Item 8 Per FH FilmG770 4-14-99 rja

99 12269

|   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John C. Baker</b>   |   |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>11</b> Year <b>1999</b> |  | 3. Time of Death<br><b>12:26 AM</b>  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Baltimore Veterans Administration</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |  | 4c. County of Death<br><b>Baltimore City</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>245-34-2912</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br><b>7-4-27</b><br>(Month, Day, Year)  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>  |
|   | Usual Residence of Decedent  |   |  |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2525 Tolley Street</b>   |  |   |  | 10f. Zip Code<br><b>21230</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>                        |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary (Secondary (0-12)) <b>6</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>   |   |  | 16b. Kind of Business/Industry<br><b>Building</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Baker</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary F. Kirby/Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 West Elizabeth Street Del Mar, MD 21875</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lake View Memorial Park</b>  |   | Date<br><b>04/14/99</b>  |  | 20c. Location - City or Town, State<br><b>Sykesville, MD</b>   |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Ambrose Funeral Home of Lansdowne<br/>2719 Hammonds Ferry Road Lansdowne, MD 21227</b>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Sepsis</b><br>Due to (or as a consequence of):   |  |   |  |   |   |  |  |  |
| b. <b>septic joint</b><br>Due to (or as a consequence of):  |  |   |  |   |   |  |  |  |
| c. <b>renal failure</b><br>Due to (or as a consequence of):   |  |   |  |   |   |  |  |  |
| d.  |  |   |  |   |   |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |  | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br><b>Adam Clark M.D.</b>   |   |  |  |  |
|   |  |   |  | 29c. License number<br><b>13-10438</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 11, 1999</b>                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Adam Clark 10 N. Greene Street</b>   |  |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |  |   |  | 32. Registrar's Signature<br><b>Beverly B. Sparks</b>   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12270

|   |  |  |  |   |  |  |  |  |   |   |  |
|---|--|--|--|---|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Ida Mae Brummel</i>   |  |  | 2. Date of Death<br>Month <i>3</i> Day <i>8</i> Year <i>1999</i>  |  |  | 3. Time of Death<br><i>1:50 PM</i>   |  |   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Cherrywood Manor N.H.</i>   |  |  | 4b. City, Town, or Location of Death<br><i>Reisterstown</i>   |  |  | 4c. County of Death<br><i>Baltimore</i>  |  |   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>219-78-3033</i>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><i>82</i> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><i>6/14/16</i>  |  | 9. Birthplace (State or Foreign Country)<br><i>Balt. MD</i> |   |  |
|   | Usual Residence of Decedent  |  |  | 10a. State<br><i>MD</i>   |  |  | 10b. County<br><i>Baltimore</i>  |  |   | 10c. City, Town or Location<br><i>Reisterstown</i>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  | 10e. Street and Number<br><i>12020 Reisterstown Rd</i>  |  |  | 10f. Zip Code<br><i>21136</i>  |  |   | 10g. Citizen of What Country?<br><i>USA</i>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>unknown</i> College (14 or 5+) <i>unknown</i>  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Not known</i>   |  |  | 16b. Kind of Business/Industry<br><i>unknown</i>   |  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>Kentzler</i>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>unknown</i>   |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Physician</i>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>as above</i>  |  |  |  |  |   |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>State Anatomy Board of Maryland</i>  |  |  | Date<br><i>3/18/97</i>   |  |   | 20c. Location - City or Town, State   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Joseph B. Van Sant per DVP</i>   |  |  | 22. Name and Address of Facility<br><i>State Anatomy Board, 655 W. Baltimore St Baltimore, MD 21201</i>   |  |  |  |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Sepsis</i><br>Due to (or as a consequence of):<br><i>foot necrosis + infection</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>malnutrition</i><br><i>dehydration</i><br><i>previous cerebrovascular Accident</i> |  |  | Approximate Interval Between Onset and Death  |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>malnutrition</i><br><i>dehydration</i><br><i>previous cerebrovascular Accident</i>  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |   |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |   |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  | 28a. Date of Injury (Month, Day, Year)  |  |  | 28b. Time of Injury<br><i>M</i>  |  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| State Registrar   | 28d. Describe how injury occurred  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  | 29b. Signature and title of certifier<br><i>Steph S. Smith MD</i>   |  |  |  |  |   |   |  |
|   | 29c. License number<br><i>D 28304</i>  |  |  | 29d. Date signed (Month, Day, Year)<br><i>3/23/99</i>   |  |  |  |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>750 Main St. Reisterstown MD 21136</i> |  |  | 31. Date filed (Month, Day, Year)<br><i>APR 14 1999</i>                    |   |  |  |  |  |   |   |  |
| 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |  |   |  |  |  |  |   |   |  |



99-2057-003

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HAROLD

State of Maryland / Department of Health and Mental Hygiene

BOPST ITEMS: #23 PART I, II, 27, 28A-F PER MEO G770

Certificate of Death

Reg. No.

99 12271

|   |  |                             |   |   |  |   |   |  |  |  |
|---|--|-----------------------------|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Harold Otis Edwin Bopst, II          |                             |   |   |  |   | 2. Date of Death<br>Month Day Year<br>APRIL 8, 1999   |  | 3. Time of Death<br>8:30P.M.                           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>103 VERNON AVE |                             |   |   |  |   | 4b. City, Town, or Location of Death<br>GLEN BURNIE   |  | 4c. County of Death<br>ANNE ARUNDEL                    |  |
| Funeral<br>Director   | 5. Social Security Number<br>212-88-8800   |                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>38 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>March 14, 1961 |  | 9. Birthplace (State or Foreign Country)<br>California |  |
|   | Usual Residence of Decedent  |                             |   |   |  |   |   |  |  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Anne Arundel |   | 10c. City, Town or Location<br>Glen Burnie  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>302 Milton Avenue   |  |                             |   | 10f. Zip Code<br>21061  |  | 10g. Citizen of What Country?<br>U. S. A.   |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  |                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+)   |  |                             |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Owner / Operator   |  |   |   | 16b. Kind of Business/Industry<br>Construction   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Harold Otis Edwin Bopst, II  |  |                             |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Patricia Hyatt   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Patricia Bopst (Mother)   |  |                             |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>302 Milton Avenue Glen Burnie, Maryland 21061  |  |   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                             |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  | Data<br>4/13 1999   |   | 20c. Location - City or Town, State<br>Brooklyn Park, Maryland                                 |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael C. Gaffney</i>  |  |                             |   |   |  | 22. Name and Address of Facility<br>Singleton Funeral Home PA<br>1 Second Avenue S.W. Glen Burnie, Maryland 21061 |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Due to (or as a consequence of):<br>a. NARCOTIC INTOXICATION<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                             |   |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br>COCAINE USE   |  |                             |   |   |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |                             |   |   |  |   |   |  |  |  |
| 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |                             |   |   |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |                             |   |   |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |                             |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE |  |   |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined  |  |                             |   | 28a. Date of Injury (Month, Day Year)<br>Found: 4-8-99  |  | 28b. Time of Injury<br>Found: 7:20 P M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>FOUND IN A GARRAGE  |  |                             |   | 28d. Describe how injury occurred<br>UNKNOWN  |  |   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>103 VERNON AVE.   |  |                             |   |   |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                             |   |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><i>J. Pentamer, M.D.</i>   |  |                             |   | 29c. License number<br>O.C.M.E.   |  |   | 29d. Date signed (Month, Day, Year)<br>APRIL 9, 1999  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Pestamer 111 Penn Street, Baltimore, Maryland 21201  |  |                             |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 14 1999  |  |                             |   | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

39 12272

|  |  |                                 |   |  |  |   |   |  |   |   |  |
|--|--|---------------------------------|---|--|--|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Deborah Baker</b>   |                                 |   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>April 10, 1999</b>                                     |  | 3. Time of Death<br><b>15:20</b>                            |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland, 22 S. Greene Street Baltimore</b> |                                 |   |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-66-9084</b>  |                                 | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>April 20, 1954</b>                                    |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |  |
|  | Usual Residence of Decedent  |                                 |   |  |  |   |   |  |   |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b> |   | 10c. City, Town or Location<br><b>Catonsville</b>  |  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |
| 10e. Street and Number<br><b>1314 Denbright Road</b>   |  |                                 |   | 10f. Zip Code<br><b>21228</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>1</b>   |  |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Landscaper</b> |  |   | 16b. Kind of Business/Industry<br><b>Landscaping</b>  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Virgil Baker</b>   |  |                                 |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Virginia (Bradley)</b>   |   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Virgil Baker (Father)</b>   |  |                                 |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6124 Collinsway Road, Catonsville, MD 21228</b> |   |  |   |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |                                 |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. John's Cemetery</b>                           |  | Date<br><b>4/13/99</b>  |   | 20c. Location - City or Town, State<br><b>Ellicott City, MD</b>  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Handa L Lemmer</b>   |  |                                 |   |  |  | 22. Name and Address of Facility<br><b>Witzke Funeral Homes, Inc.<br/>1630 Edmondson Avenue, Catonsville, MD 21228</b>                              |   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Chronic Myelogenous Leukemia</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  |                                 |   |  |  |   |   |  |   | Approximate Interval Between Onset and Death<br><b>1 year</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>   |  |                                 |   |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |  |
|  |  |                                 |   |  |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |
|  |  |                                 |   |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                 | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |   |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |                                 | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |   |  |
|  |  |                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                    |  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                                 |   |  |  |   |   |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Kelly Ellis MD</b>   |  |                                 |   |  |  | 29c. License number<br><b>P12390</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 10, 1999</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kelly Ellis MD - 22 S. Greene Street, Baltimore MD</b>  |  |                                 |   |  |  |   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |  |                                 | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |   |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

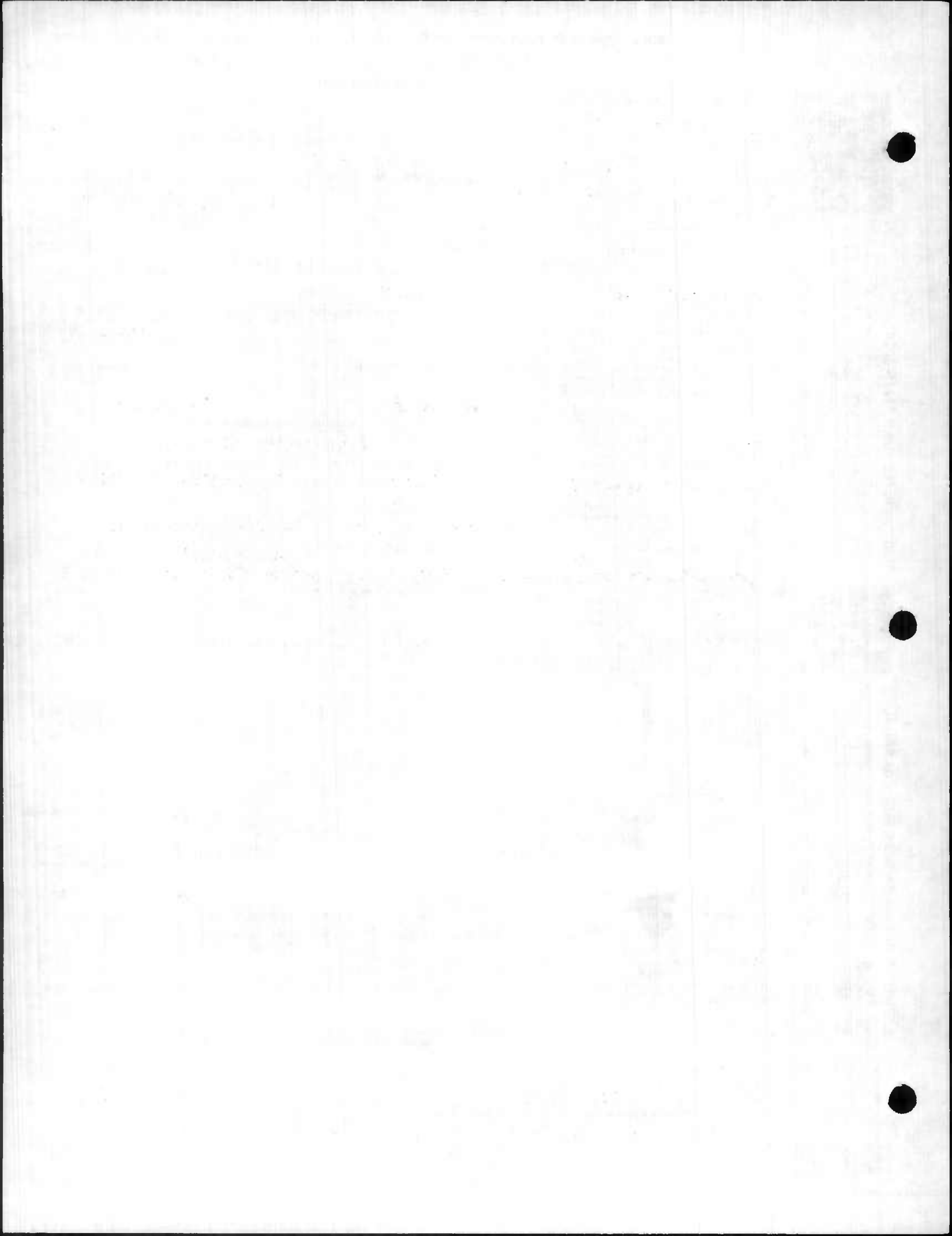
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12273

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Frances Bacon

2. Date of Death

April 10 1999

3. Time of Death

9:10 AM

4e. Facility Name (If not institution, give street and number)

Westminster Nursing Home

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

212-07-5863

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 27 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Md

10b. County

Baltimore

10c. City, Town or Location

Carmey

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3025 East Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

quality controller

16b. Kind of Business/Industry

Henson, Westcott + Dunning Com.

17. Father's Name (First, Middle, Last)

John Schulte

18. Mother's Name (First, Middle, Maiden Surname)

Lutricia Hanley

19e. Informant's Name/Relationship (Type, Print)

Wilson Bacon

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

son 2516 Appaloosa Way Finksburg, Md 21048

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park

Date

April 14 1999

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

EVANS Funeral Chapel 8800 Hatford Rd Baltimore Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

b. ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

4 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENZA

GASTRIC ULCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard B. Latham

29c. License number

D 17042

29d. Date signed (Month, Day, Year)

4/12/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

HOWARD B. LATHAM, MD 215 WASHINGTON HGB3 MED CTR WESTMINSTER 21157

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

Howard B. Latham

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12274

patient known as Michael Brown

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL P. BROWN</b>   |  | 2. Date of Death<br>Month <b>April</b> Day <b>9</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>908 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>  |
| 5. Social Security Number<br><b>214-62-9522</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>APR. 7, 1953</b>   |
| Usual Residence of Decedent   |  |   | 9. Birthplace (State or Foreign Country)<br><b>BALTO, MARYLAND</b>   |  |  |
| 10a. State<br><b>MARYLAND</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>3124 CLIFTMONT AVENUE</b>  |  |   | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4or 5+) <b>MASTERS' EQUIVALENT</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BALTIMORE CITY SCHOOL TEACHER</b>   |  | 16b. Kind of Business/Industry<br><b>BALTIMORE CITY DEPT. OF EDUCATION</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>KENNETH AMBROSE</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>SARAH PURNELL</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARILYN H. SMITH-BROWN (wife)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3124 CLIFTMONT AVE. BALTO, MD. 21213</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEM. PARK</b>  |  | 20c. Location - City or Town, State<br><b>APR. 15, 1999 BALTO, MD.</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Calvin B. Scruggs, Jr.</i>  |  |   | 22. Name and Address of Facility<br><b>CALVIN B. SCRUGGS FUNERAL HOME<br/>1412 E. PRESTON ST. BALTO, MD. 21213</b>                           |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Pulmonary Embolus</b><br>Due to (or as a consequence of):<br><br>b. <b>Right lower extremity deep vein thrombosis</b><br>Due to (or as a consequence of):<br><br>c. <b>Prolonged bedrest</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Approximate Interval Between Onset and Death<br><br><b>3 weeks</b><br><br><b>3 months</b> |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acquired immuno-deficiency syndrome</b>  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how Injury occurred  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>K. Barnard</i>  |  | 29c. License number<br><b>P12304</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 9, 1999</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. KATHRYN BARNARD 2401 WEST BELVEDERE BALTO, MD.</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 12275

|  |   |   |  |  |  |  |  |  |
|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>John K. Blackhurst  |   |  |  | 2. Date of Death<br>Month Day Year<br>April 13, 1999 |  | 3. Time of Death<br>10:50 AM                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Cromwell Center - Genesis ElderCare |   |  |  | 4b. City, Town, or Location of Death<br>Parkville    |  | 4c. County of Death<br>Baltimore                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-20-4857  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>72 Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br>May 16 1926 |  |
|  | 9. Birthplace (State or Foreign Country)<br>MD  |   | 10a. State<br>MD   |  | 10b. County<br>Baltimore                             |  | 10c. City, Town or Location<br>Dundalk             |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br>3107 Cornwall Rd  |  | 10f. Zip Code<br>21222   |  | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Steelworker                              |  | 16b. Kind of Business/Industry<br>Tin Mill   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>John Blackhurst   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie Buckley   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Barbara Montgomery /daughter   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>17 David Luther Ct. Timonium, MD  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holly Hill Memorial   |  | 20c. Location - City or Town, State<br>Middle River, MD  |  | 20d. Date<br>April 17 1999   |  |  |
| 21. Signature of Funeral Service Licensee<br>Anthony C. Connelly   |   |   |  | 22. Name and Address of Facility<br>Connelly Funeral Home of Dundalk<br>7110 Sollers Point Rd 21222  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>RESPIRATORY FAILURE</u><br>Due to (or as a consequence of):<br>b. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br>Due to (or as a consequence of):<br>c. <u>END STAGE RENAL DISEASE</u><br>Due to (or as a consequence of):<br>d. <u>CORONARY ARTERY DISEASE</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>V. BHAWDIYA   |   | 29c. License number<br>DS2228   |  | 29d. Date signed (Month, Day, Year)<br>4/13/99   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>3007 E. NORTHERN PKWY BALTIMORE, 21214   |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 14 1999   |   | 32. Registrar's Signature<br>B. Sparks  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

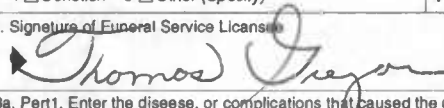
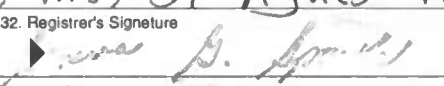


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 12276

|   |   |                       |   |  |  |  |  |  |
|---|---|-----------------------|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Leona Elizabeth Chapman                 |                       |   |  | 2. Date of Death<br>Month Day Year<br>April 7 1999   |  | 3. Time of Death<br>1450   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>St Agnes Hospital |                       |   |  | 4b. City, Town, or Location of Death<br>Baltimore  |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-56-9271  |                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>93 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>June 11, 1905   | 9. Birthplace (State or Foreign Country)<br>Washington   |
|   | Usual Residence of Decedent   |                       |   |  |  |  |  |  |
| 10a. State<br>MD  |   | 10b. County<br>Howard |   | 10c. City, Town or Location<br>Hanover   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>6179 Hanover Rd.  |   |                       |   | 10f. Zip Code<br>21076   |  | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 College (1-4or 5+)   |   |                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker/Nurse           |  | 16b. Kind of Business/Industry<br>Own Home/Private Doctor  |  |  |
| 17. Father's Name (First, Middle, Last)<br>William Wallace Martin   |   |                       |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nancy Chelliah Hart   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Lonnica M. Florey - daughter  |   |                       |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6165 Hanover Road, Hanover, Md. 21076 |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Memorial Pk.  |  | Date<br>4/10/99  | 20c. Location - City or Town, State<br>Elkridge, Md.   |  |  |
| 21. Signature of Funeral Service Licenses<br>   |   |                       |   | 22. Name and Address of Facility<br>Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.<br>7250 Washington Blvd., Elkridge, Md. 21075  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Congestive Heart Failure<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |                       |   |  |  |  |  | Approximate Interval Between Onset and Death<br>10 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Coronary Artery Disease<br>Chronic Obstructive Pulmonary Disease  |   |                       |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |                       | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|   |   |                       | 28d. Describe how injury occurred   |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                       | 29b. Signature and title of certifier<br>H. Wang, MD  |  |  | 29c. License number<br>P10883  |  | 29d. Date signed (Month, Day, Year)<br>April 7, 1999     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Henry Wang, MD, St Agnes Hospital, Baltimore, MD  |   |                       |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 14 1999  |   |                       | 32. Registrar's Signature<br>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

NAME Chapman, Leona  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar  
DHMH 16 Rev 6/95





99 12277

ORIGINAL

DHHH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**





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State of Maryland / Department of Health and Mental Hygiene

99 12278

CHARLES  
CROUCHER

## Certificate of Death

Reg. No.

|  |  |   |   |   |   |  |  |
|--|--|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>CHARLES ADAM CROUCHER  |   |   |   | 2. Date of Death<br>Month Day Year<br>APRIL 11, 1999  |  | 3. Time of Death<br>3:45 P.M.                                    |
|  | 4a. Facility Name (If not institution, give street and number)<br>OLD YORK ROAD & SAMPSON ROAD   |   |   | 4b. City, Town, or Location of Death<br>Maryland Line   |   | 4c. County of Death<br>BALTIMORE   |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-30-4629   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>65 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Oct. 9, 1933  | 9. Birthplace (State or Foreign Country)<br>Md.                  |
|  | Usual Residence of Decedent  |   |   |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Pa.  | 10b. County<br>York   | 10c. City, Town or Location<br>Stewartstown   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>99 Smoke Box Circle  |   |   | 10f. Zip Code<br>17363  |   | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 5/13/54 - 4/27/56 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales man  |   |   | 16b. Kind of Business/Industry<br>Lee L. Dopkin  |  |
|  | 17. Father's Name (First, Middle, Last)<br>John T. Croucher  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Habersack  |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Ms. Diane E. Croucher/daughter   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10 Camelot Ct. Stewartstown, Pa. 17363 |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery   |   | Data<br>4/16/99   | 20c. Location - City or Town, State<br>Parkville, Md.  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204                                   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Multiple Injuries<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |   |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
|  |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE                               |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br>4 11 99   |   | 28b. Time of Injury<br>1317 PM  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Roadway   |   | 28d. Describe how injury occurred. Shorten as<br>DRIVEN OFF CAR, IMPACT WITH<br>OLD YORK RD BALTIMORE CO. MD                            |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Medical Examiner   |  | 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br>O.C.M.E.   |   | 29d. Date signed (Month, Day, Year)<br>APRIL 12, 1999   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MAYSA A. KIDNEY 111 Penn Street, Baltimore, Maryland 21201   |  |   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 14 1999   |  | 32. Registrar's Signature<br>   |   |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12279

|  |   |  |                               |   |  |  |  |  |
|--|---|--|-------------------------------|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>L Allen Chalker, Jr.</b>                         |  |                               |   | 2. Date of Death<br>Month Day Year<br><b>April 9, 1999</b> |  | 3. Time of Death<br><b>10:00 PM</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital</b> |  |                               |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b> |  | 4c. County of Death<br><b>Anne Arundel</b>                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-22-7011</b>   |  | 6. Sex<br><b>1 M 2 F</b>      |   | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>March 12, 1929</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                     |  | 10a. State<br><b>Maryland</b> |   | 10b. County<br><b>Anne Arundel</b>                         |  | 10c. City, Town or Location<br><b>Glen Burnie</b>            |  |
| 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |   | 10e. Street and Number<br><b>918 Blakistone Road</b>   |                               | 10f. Zip Code<br><b>21060</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>   |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b>                       |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) Collage (1-4or 5+) +1</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bus Driver</b>                       |                               | 16b. Kind of Business/Industry<br><b>Transportation</b>   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lloyd A. Chalker, Sr.</b>  |   |  |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Hughes</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Chalker (Wife)</b>  |   |  |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>918 Blakistone Road Glen Burnie, Maryland 21060</b> |  |  |  |  |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>  |                               | 20c. Location - City or Town, State<br><b>4-13-99 Baltimore Maryland</b>  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   | 22. Name and Address of Facility<br><b>Singleton Funeral Home, PA<br/>1 Second Ave. S.W. Glen Burnie, Maryland 21061</b>                             |                               |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Massive Hemoptysis</b><br>Due to (or as a consequence of):<br><b>b. Chronic Obstructive pulmonary disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Type two diabetes</b><br><b>Obesity</b><br><b>Congestive heart failure</b> |   |  |                               |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Type two diabetes</b><br><b>Obesity</b><br><b>Congestive heart failure</b>  |   |  |                               |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |  |  |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |                               |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |                               |   |  |  |  |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>  |   | 28a. Date of Injury (Month, Day, Year)   |                               | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |                               | 29c. License number<br><b>D41927</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4-10-99</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jorge Perez-Alamo, M.D. 3708 Mountain Rd Pasadena, MD 2122</b>  |   |  |                               |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |                               |   |  |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12280

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>VINCENT de Paul CAPLINS</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 11, 1999</b>  |  | 3. Time of Death<br><b>9:30 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>8365 WILLIAMSTOWNE DRIVE</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>MILLERSVILLE</b>  |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |
| 5. Social Security Number<br><b>213-58-1627</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 7, 1954</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ANNE ARUNDEL</b>   |  | 10c. City, Town or Location<br><b>MILLERSVILLE</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>8365 WILLIAMSTOWN DRIVE</b>  |  | 10f. Zip Code<br><b>21108</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LIEUTENANT FIRE FIGHTER</b>   |  | 16b. Kind of Business/Industry<br><b>ANNE ARUNDEL FIRE DEPARTMENT</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ALPHONSE CAPLINS</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LILLIAN RUTKAUSKIS</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>VICKI CAPLINS (WIFE)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8365 WILLIAMSTOWNE DRIVE, MILLERSVILLE, MD. 21108</b>                                    |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MEADOWRIDGE MEMORIAL PARK</b>  |  | 20c. Date<br><b>4/16/99</b>  |  | 20d. Location - City or Town, State<br><b>ELKRIDGE, MD.</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael C. Taffel</i>  |  |   |  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.  |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>HEPATIC FAILURE</b>  |  |   |  |  |  | <b>1 month</b>   |  |
| Due to (or as a consequence of):   |  |   |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>MALIGNANT CARCINOMA</b>   |  |   |  |  |  | <b>&gt; 2 YRS</b>  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>D. G. I. W.</i>  |  |   |  | 29c. License number<br><b>D27730</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/14/99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GARY COHEN, MD. 6569 N. CHARLES ST. BALTIMORE, MD.</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |  |   |  | 32. Registrar's Signature<br><i>B. Sparks</i>  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Kendall Christianson ITEM: 23 PART 1, 27, PER MEO 5-6-99 G771 J.A.  
Item# 5perFH G770 4/14/99 EW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12281

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Kendall Clark Christianson

2. Date of Death  
Month Day Year  
April 08, 19993. Time of Death  
6:00 P.M.

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

218-53-7426

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

December 9, 1998

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10241 Red Lion Tavern Ct.

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Navar Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

"NA"

16b. Kind of Business/Industry

"NA"

17. Father's Name (First, Middle, Last)

David Clark Christianson

18. Mother's Name (First, Middle, Maiden Summa)

Melissa Ann Curkendall

19a. Informant's Name/Relationship (Type, Print)

Mr. David Clark Christianson Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10241 Red Lion Tavern Ct. Ellicott City, Maryland 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Columbia Memorial Park

Date

04/12/99

20c. Location - City or Town, State

Clarksville, Maryland

21. Signature of Funeral Service Licensee

m00535

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SUDDEN INFANT DEATH SYNDROME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph P. Pustaner, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 09, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pustaner

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12282

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL DENTZ

2. Date of Death  
Month Day Year  
APRIL 13, 1999

3. Time of Death  
3:30 AM

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-07-1741

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

03/24/11

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2214 WESTFIELD AVENUE

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BARBER

16b. Kind of Business/Industry

BARBER

17. Father's Name (First, Middle, Last)

HENRY DENTZ

18. Mother's Name (First, Middle, Maiden Surname)

LUCY KRECKLE

19a. Informant's Name/Relationship (Type, Print)

CAROLE SPURRIER DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1522 GLEN KEITH BLVD. BALTIMORE, MD 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DULANEY VALLEY MEM. GAR. 4/16/99 COCKEYSVILLE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Heather W. Hays*

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.  
8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive C.-dis myopathy

Approximate Interval Between Onset and Death

Yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

Yrs.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Louis E. Gronzer*

29c. License number

D01442

29d. Date signed (Month, Day, Year)

Apr 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louis E. Gronzer M.D. 301st. Pulpline #815 B. H. Md

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

*Berna A. Hays*

21202

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12283

|  |   |  |   |  |  |   |  |  |  |  |
|--|---|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Joseph Defina   |  |   |  |  | 2. Date of Death<br>Month Day Year<br>April 12, 1999  |  |  | 3. Time of Death<br>3:00am                           |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>308 Lee Drive   |  |   |  |  | 4b. City, Town, or Location of Death<br>Catonsville   |  |  | 4c. County of Death<br>Baltimore                     |  |
| Funeral<br>Director                              | 5. Social Security Number<br>213-07-7413  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>90 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>April 28, 1908                                |  | 9. Birthplace (State or Foreign Country)<br>New York |  |
|  | Usual Residence of Decedent   |  |   |  |  |   |  |  |  |  |
| To Be Completed by Funeral Director              | 10a. State<br>MD  |  | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Catonsville   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>308 Lee Drive   |  |   |  | 10f. Zip Code<br>21228   |   | 10g. Citizen of What Country?<br>USA   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Draftsman   |   |  | 16b. Kind of Business/Industry<br>Bethlehem Steel  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Frank Defina   |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carmela Marotta  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner    | 19a. Informant's Name/Relationship (Type, Print)<br>John J. Strauch Son-in-Law  |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>44 Montvieu Court, Hunt Valley, MD 21030   |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Loudon Park Cemetery  |  |  | Date<br>4/15/99   |  | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Robert G. Beck   |  |   |  |  | 22. Name and Address of Facility<br>Witzke Funeral Homes, Inc.<br>1630 Edmondson Avenue, Catonsville, MD 21228                              |  |  |  |  |
|  | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>s. Chondroma Rectum<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>5 Yrs |  |   |  |  |   |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |   |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                    |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |  |
| State<br>Registrar                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |   |  |  |  |  |
|  | 29b. Signature and title of certifier<br>[Signature] MD   |  |   |  |  | 29c. License number<br>D33448   |  | 29d. Date signed (Month, Day, Year)<br>April 12 99   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>1120 N. Rolling Road Baltimore, MD 21228  |  |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 14 1999 |   |  |   |  | 32. Registrar's Signature<br>[Signature]   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12284

|   |   |   |  |  |   |  |  |   |
|---|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph L. Edwards</b>                      |   |  |  | 2. Date of Death<br>Month Day Year<br><b>April 11, 99</b> |  | 3. Time of Death<br><b>09:14am</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1701 Eutaw Place</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>NA</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>239-32-6411</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                            | 8. Date of Birth (Month, Day, Year)<br><b>10-31-21</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>NC</b> |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>1701 Eutaw Place</b>   |   |   |  | 10f. Zip Code<br><b>21217</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+) <b>NA</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction worker</b>  |   |  | 16b. Kind of Business/Industry<br><b>Construction Co.</b>                                      |   |
| 17. Father's Name (First, Middle, Last)<br><b>John Edwards</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Jordan</b>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Burns</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1535 Darren Circle Portsmouth, VA. 23701</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Cemetery 04-16-99</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C.March FH 1101 E. North Avenue</b>  |   |  |  |   |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ESSENTIAL HYPERTENSION</b><br><b>CARDIAC ARRYTHMIAS</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                     |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D24100</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4-13-99</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. ADURA L. PRABHAKARM 2115 OLD FOREMS ROAD BAL.</b>   |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |   | 32. Registrar's Signature<br>   |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12285

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Henry Andrew Eyster

2. Date of Death

Month Day Year  
April 10, 1999

3. Time of Death

7:25 AM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

217-07-1999

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 30 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Freeland

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2118 Freeland Rd

10f. Zip Code

21053

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

conductor & brakeman

16b. Kind of Business/Industry

Southern Pacific Railroad

17. Father's Name (First, Middle, Last)

John F. Eyster

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Brownsberger

19a. Informant's Name/Relationship (Type, Print)

Arnell H. McCarron

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2118 Freeland Rd. Freeland, Md 21053

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel-Belair

Date

April 13 1999

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

Christa S. Welke

22. Name and Address of Facility

Evans Chapel of Memories  
8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

COPD

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal insufficiency  
Coronary artery disease  
Pacemaker

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide  
☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Michael D. Fagg

29c. License number

H18792

29d. Date signed (Month, Day, Year)

4/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. James Ricely 6701 N. Charles St. Towson, Md 21204

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12286

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Adam Christopher Feaga

2. Date of Death  
Month Day Year

April 10, 1999

3. Time of Death

6:32 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Cumberland Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

218-96-6734

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

28 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 10, 1970

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3804 Sykesville Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Christopher A. Feaga

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Driver

19a. Informant's Name/Relationship (Type, Print)

Mr. Christopher A. Feaga Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5830 Ten Oaks Road Clarksville, Maryland 21029

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Louis Cemetery

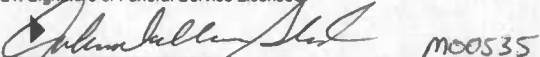
Date

04/15/99

20c. Location - City or Town, State

Clarksville, Maryland

21. Signature of Funeral Service Licensee

 m00535

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries  
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

4 10 99

28b. Time of Injury

3:30 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

DRIVEN OFF TRUCK, SIMILAR TO

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

CAMP GROUND

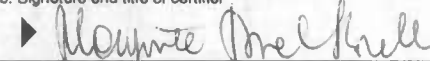
28f. Location (Street and Number or Rural Route Number, City or Town, State)

PAW-PAW WEST VIRGINIA

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

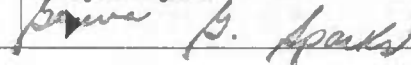
HARRY DAVIS &amp; KOSOW INC

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12287

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><u>Arthur Granville Ford, Jr.</u>  |  |   |  | 2. Date of Death<br>Month <u>April</u> Day <u>9</u> Year <u>1999</u>   |  | 3. Time of Death<br><u>8:45AM</u>                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Manor Care - Ruxton</u>   |  |   |  | 4b. City, Town, or Location of Death<br><u>Towson</u>  |  | 4c. County of Death<br><u>Baltimore</u>                                 |  |
| Funeral<br>Director                           | 5. Social Security Number<br><u>214-38-6761</u>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>77</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>March 15, 1922</u>            |  |
|   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>  |  | 10a. State<br><u>Md.</u>  |  | 10b. County<br><u>Baltimore</u>  |  | 10c. City, Town or Location<br><u>Parkville</u>                         |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><u>2613 Meadowland Ct.</u>  |  | 10f. Zip Code<br><u>21234</u>  |  | 10g. Citizen of What Country?<br><u>USA</u>                             |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>-</u>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>operations officer</u>  |  | 16b. Kind of Business/Industry<br><u>U.S. Customs Services</u>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>Arthur G Ford, Sr.</u>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Hilda K. Tress</u>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Arthur G. Ford III</u>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>115 John St. Perryville Maryland 21903</u>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>New Cathedral Ceme.</u>   |  | 20c. Location - City or Town, State<br><u>Baltimore Maryland</u>        |  |
|   | 21. Signature of Funeral Service Licensee<br><u>Krista J. Webb</u>   |  | 22. Name and Address of Facility<br><u>Evans Funeral Chapel</u>   |  | 22. Name and Address of Facility<br><u>8800 Harford Rd. Baltimore, Md 21234</u>  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>Acute Myocardial Infarction</u><br>Due to (or as a consequence of):<br><u>Coronary Artery Disease</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><u>Chronic Renal Failure</u><br><u>Chronic Obstructive Pulmonary Disease</u> |  | Approximate Interval Between Onset and Death<br><u>1 hour</u><br><u>10 years</u>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><u>[Signature]</u>   |  | 29c. License number<br><u>D34124</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>4-12-99</u>                   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Dr. John W. Miller 1205 York Rd suite 20 Timonium, Md.</u>  |  | 31. Date filed (Month, Day, Year)<br><u>APR 14 1999</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12288

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nadean Finkle

2. Date of Death

Month Day Year  
APRIL 13 1999

3. Time of Death

6:50 AM

4a. Facility Name (If not institution, give street and number)

Oak Crest Care Center

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-52-5394

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 9 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8830 Walther Blvd. #321

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Frederick Winterling

18. Mother's Name (First, Middle, Maiden Summa)

Catherine McGainey

19a. Informant's Name/Relationship (Type, Print)

Mrs. Yvonne Crawford/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

600 Squire Lane 2C Bel Air, MD. 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

4-15-99

20c. Location - City or Town, State

Parkville, MD.

21. Signature of Funeral Service Licensee

K. J. R.

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GANGRENE, Right Leg

Due to (or as a consequence of):

b. Peripheral vascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

&gt; 6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Chronic lung disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury of Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hendrick Faulkner

29c. License number

D25643

29d. Date signed (Month, Day, Year)

4/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. R. Faulkner MD / 8800 Walther Blvd / Baltimore MD 21234

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12289

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys L. Grim

2. Date of Death

Month Day Year  
April 13, 1999

3. Time of Death

2:35 p.m.

4e. Facility Name (If not institution, give street and number)

7548 Old Telegraph Road

4b. City, Town, or Location of Death

Hanover

4c. County of Death

Anne Arundel Co.

Funeral  
Director

5. Social Security Number

218-05-1357

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 31, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Anne Arundel Co.

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7614 Beach Drive

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Herman Moore

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Adams

19e. Informant's Name/Relationship (Type, Print)

Mrs. Gloria Lavinder (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7612 Beach Drive Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Druid Ridge Cemetery April 16, 1999 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ *Valerie S. Polyniak*

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

3204 Mountain Road Pasadena, Maryland 21122

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart Failure  
Stroke

Approximate interval Between Onset and Death

2 years  
6 months

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Morning Side Hospice

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *Elliott Gorbaty*

29c. License number

D20094

29d. Date signed (Month, Day, Year)

04/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elliott Gorbaty 3845 Oakwood Rd, Glen Burnie, Md, 21061

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

▶ *B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12290

Item#20b,20c perFHG770 4/22/99 EW

Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Jasmine L. Gunthorpe  |  |   |  | 2. Date of Death<br>Month Day Year<br>04 12 99  |  | 3. Time of Death<br>1910   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>University of Maryland Hospital   |  |   |  | 4b. City, Town, or Location of Death<br>Baltimore   |  | 4c. County of Death<br>Baltimore City  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>580-16-1671  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>43 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>10-10-55                                      |  |
|   | 9. Birthplace (State or Foreign Country)<br>US VI   |  | 10a. State<br>MD  |  | 10b. County<br>WA   |  | 10c. City, Town or Location<br>BALTIMORE   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>3022 Mosher Street  |  | 10f. Zip Code<br>21216  |  | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WEST INDIAN               |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Executive Assistant                      |  | 16b. Kind of Business/Industry<br>Revitalization Corp.  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Sydney Gunthorpe   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Flavie O'Neal  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Lawrence H. Outlaw Husband  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3022 Mosher Street BALTIMORE, MD 21216   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Mary's Church Cem.  |  | 20c. Location - City or Town, State<br>Charlotte, AL  |  | 20d. Date<br>4-22-99   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>[Signature]  |  |   |  | 22. Name and Address of Facility<br>Albert P. Wylie 714 PA<br>638 N. Gilman Street BALTIMORE, MD 21217  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Increased Intra Cranial Pressure<br>Due to (or as a consequence of):<br>Intra Cerebral Hemorrhage<br>Due to (or as a consequence of):<br>Cerebro Vascular Accident<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>Sub Arachnoid Hemorrhage |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>[Signature] M.D.   |  | 29c. License number (Resident)<br>P1411   |  | 29d. Date signed (Month, Day, Year)<br>04-13-99                                      |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>HUGO A. TORRES 22 South Greene Street; Baltimore, MD  |  |   |  |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>APR 14 1999  |  |   |  | 32. Registrar's Signature<br>[Signature]  |  |  |  |

Baltimore, Maryland 21215-0020  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12291

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David

2. Date of Death

April 11 1999

3. Time of Death

7:35 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore, City

4c. County of Death

N/A

5. Social Security Number

218-74-8874

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 25 1958

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6616 Bushey St

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Installer

16b. Kind of Business/Industry

Heating &amp; Air Cond.

17. Father's Name (First, Middle, Last)

William J. Gegorek Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Helen Giza

19a. Informant's Name/Relationship (Type, Print)

Sharon Humphrey /sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6616 Bushey St Baltimore, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Stanislaus Cem.

Date

April 15

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk  
7110 Sollers Point Rd 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracerebral hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prosthetic aortic valve, therapeutic anticoagulation with coumadin

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael A. Williams, MD

29c. License number

040091

29d. Date signed (Month, Day, Year)

April 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 N. Wolfe Street Baltimore, MD 21287

Michael A. Williams, MD

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

Jenna B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12292

|  |   |  |   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
|--|---|--|---|--|---|--|--|---|---|---|----|--|-----------------|----------------------------------|--|--|----|-------------------------------|-----------------|----------------------------------|--|--|----|----------------------------------|--|--|----|----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH J. HOLDEN</b>                          |  |   |  |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>7</b> Year <b>1999</b> |  | 3. Time of Death<br><b>0005</b>   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND</b> |  |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>             |  | 4c. County of Death<br><b>BALTIMORE</b>                                 |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-20-3561</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                       | 8. Date of Birth (Month, Day, Year)<br><b>MAR 1, 1926</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
|  | Usual Residence of Decedent   |  |   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>N/A</b>                |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 10e. Street and Number<br><b>102 S. Poppleton Street</b>   |   |  |   |  | 10f. Zip Code<br><b>21201</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b></b>  |   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Swiss Embroidery</b>  |  |  | 16b. Kind of Business/Industry<br><b>Garment</b>                        |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edwin Leo Emich</b>  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Louise Schmidt</b>  |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Leo Holden - son</b>  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>102 S. Poppleton St., Baltimore, Md. 21201</b>  |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery</b>   |  |   | Date<br><b>4/09/99</b>   | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>   |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  |   |  | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.<br/>7250 Washington Blvd., Elkridge, Md. 21075</b>   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>NECROTIZING SOFT TISSUE INFECTION</b></td> <td><b>2 months</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>RECURRENT COLON CANCER</b></td> <td><b>2 months</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3">Due to (or as a consequence of):</td> </tr> </table> |   |  |   |  |   |  |  |   |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | <b>NECROTIZING SOFT TISSUE INFECTION</b> | <b>2 months</b> | Due to (or as a consequence of): |  |  | b. | <b>RECURRENT COLON CANCER</b> | <b>2 months</b> | Due to (or as a consequence of): |  |  | c. | Due to (or as a consequence of): |  |  | d. | Due to (or as a consequence of): |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | a.  | <b>NECROTIZING SOFT TISSUE INFECTION</b> | <b>2 months</b>   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
|  | Due to (or as a consequence of):  |  |   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
|  | b.  | <b>RECURRENT COLON CANCER</b>            | <b>2 months</b>   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
|  | Due to (or as a consequence of):  |  |   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| c.   | Due to (or as a consequence of):  |  |   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| d.   | Due to (or as a consequence of):  |  |   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
|  |   |  |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
|  |   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred                           |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 29b. Signature and title of certifier<br>   |   |  |   |  | 29c. License number<br><b>07966</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 7 1999</b>   |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 30. Name and address of person who completed cause of death (Form 23a) (Type, Print)<br><b>JOSEPH GIBSON BUSSEY III 22 SOUTH GREEN ST BALTIMORE MD 21230</b>   |   |  |   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |   |  | 32. Registrar's Signature<br>   |  |   |  |  |   |   |   |    |  |                 |                                  |  |  |    |                               |                 |                                  |  |  |    |                                  |  |  |    |                                  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12293

ITEMS: #23 PART I, 27 PER MEO G770 4-21-99 WR.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Laura Denise Heiland

2. Date of Death

Month Day Year  
APRIL 06, 1999

3. Time of Death

20:14 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

217-66-4323

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 11, 1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1235 Pekin Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
N/A16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Rural Carrier

16b. Kind of Business/Industry

Post Office

17. Father's Name (First, Middle, Last)

Kenneth Weigman

18. Mother's Name (First, Middle, Maiden Surname)

Patricia Emich

19a. Informant's Name/Relationship (Type, Print)

Gilbert E. Heiland Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1235 Pekin Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery April 12, 1999

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Walter Melkree

29c. License number

OCME

29d. Date signed (Month, Day, Year)

APRIL 07, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walter Melkree - Korzun

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

Benita B. Sparks

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12294

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Indo Hahn</b>  |  | 2. Date of Death<br>Month <b>APR</b> Day <b>11</b> Year <b>99</b>   |   | 3. Time of Death<br><b>0825A</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |   | 4c. County of Death<br><b>Howard</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>111-38-4763</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>April 30, 1915</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Korea</b>  |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Howard</b>   |
|   | 10c. City, Town or Location<br><b>Ellicott City</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   | 10e. Street and Number<br><b>10211 Sunway Terrace</b>   |  | 10f. Zip Code<br><b>21042</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+)   |   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Home</b>   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Kih Soon Bang</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Soo Shie Kim</b>  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Hyo-Kun Hahn Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10211 Sunway Terrace Ellicott City, Maryland 21042</b>  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fairview Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Westfield, New Jersey</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature] MD0535</b>  |  | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21043</b>  |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |  |   |   | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiorgan Dysfunction Syndrome</b>  |  |   |   | <b>18 Hours</b>  |
|   | Due to (or as a consequence of):<br><b>b. Septic Shock</b>  |  |   |   | <b>24 Hours</b>  |
|   | Due to (or as a consequence of):<br><b>c. Colon Perforation</b>   |  |   |   | <b>36 Hours</b>  |
|   | Due to (or as a consequence of):<br><b>d. Colon Carcinoma</b>   |  |   |   | <b>36 Hours</b>  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Respiratory Failure</b>  |  |   |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                           |  |   |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>                           |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |  |
| 29b. Signature and title of certifier<br><b>[Signature] MD</b>  |   | 29c. License number<br><b>00052940</b>                                       |   | 29d. Date signed (Month, Day, Year)<br><b>APR 11 1999</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SANTAY P. SHAH, MD 10805 Hickory Ridge Rd #210, Columbia, MD 21046</b>   |   |  |   |   |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12295

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Byron A. Jones   |  |  |  | 2. Date of Death<br>Month Day Year<br>April 12, 1999  |  | 3. Time of Death<br>5:15 A.M.   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel General Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Annapolis   |  | 4c. County of Death<br>Anne Arundel   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>212-04-0868   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>22 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>1-13-1977  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Md   |  | 10a. State<br>Md   |  | 10b. County<br>Severn   |  | 10c. City, Town or Location<br>Severn   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br>8231 Autumn Lake Court  |  | 10f. Zip Code<br>21144  |  |
|   | 10g. Citizen of What Country?<br>U S A   |  |  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11th grade<br>College (1-4 or 5+) NA                   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Unk   |  |  |  | 16b. Kind of Business/Industry<br>Unk   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>James Jones   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Shirley Wilson   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Shirley Gardner - Mother   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8231 Autumn Lake Court Severn, Md 21144  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arbutus Memorial Park   |  | 20c. Location - City or Town, State<br>4-15-99 Arbutus, Md  |  |
|   | 21. Signature of Funeral Service licensee<br><i>John B. Johnson Jr.</i>  |  |  |  | 22. Name and Address of Facility<br>March F/H West<br>4300 Wabash Avenue Baltimore, Md 21215  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Multiple Gunshot Wounds<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day, Year)<br>4-12-99   |  | 28b. Time of Injury<br>252 A M  |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred<br>subject shot   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>street   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Annapolis, Md   |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. Signature and title of certifier<br><i>Dennis J. Chute, M.D.</i>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br>O.C.M.E.  |  |  |  | 29d. Date signed (Month, Day, Year)<br>April 13, 1999   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute, M.D.  |  |  |  | 111 Penn Street, Baltimore, Maryland 21201  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br>APR 14 1999   |  |  |  | 32. Registrar's Signature<br><i>Byron A. Jones</i>  |  |   |  |
|   | State Registrar  |  |  |  | DHHM 16 Rev 6/95  |  |   |  |

ORIGINAL

Handwritten signature or text, possibly "J. M. Smith".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12296

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>John A. Jones, Jr                               |  |   |  | 2. Date of Death<br>Month Day Year<br>APRIL 11, 1999 |  | 3. Time of Death<br>10:50 PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>UNIVERSITY HOSPITAL S.T.U |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE    |  | 4c. County of Death  |  |
| Funeral<br>Director   | 5. Social Security Number<br>219-82-8652  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>30 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Birth (Month, Day, Year)<br>3-7-1969  | 9. Birthplace (State or Foreign Country)<br>Md   |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |  |  |
| 10a. State<br>Md  |   | 10b. County<br>NA  |   | 10c. City, Town or Location<br>Baltimore   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br>4101 Sunnyside Avenue   |   |  |   | 10f. Zip Code<br>21215   |  | 10g. Citizen of What Country?<br>U S A   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th grade<br>College (1-4or 5+) NA  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Janitor   |  | 16b. Kind of Business/Industry<br>Unk  |  |  |
| 17. Father's Name (First, Middle, Last)<br>John A. Jones, Sr  |   |  |   | 18. Mother's Name (First, Middle, Maiden Summe)<br>Ruth Carr   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Ruth Jones - Mother   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2767 W. North Avenue Baltimore, Md 21216  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arbutus Memorial Park  |  | 20c. Location - City or Town, State<br>4-16-99 Arbutus, Md   |  |  |
| 21. Signature of Funeral Service Licensee<br>Bladys Wanner  |   |  |   | 22. Name and Address of Facility<br>March F/H West<br>4300 Wabash Avenue Baltimore, Md 21215   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Multiple Gunshot Wounds<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |   |  |   |  |  |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |   |  |   |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)<br>4/11/99  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>Subject was shot  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>STREET   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>2700 Bk. W. North Ave  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner  |   | 29b. Signature and title of certifier<br>J. A. Jones, Jr   |   |  |  |  |  |  |
|   |   | 29c. License number<br>O.C.M.E   |   | 29d. Date signed (Month, Day, Year)<br>APRIL 12, 1999  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. A. Jones, Jr 111 Penn Street, Baltimore, Maryland 21201  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 14 1999  |   | 32. Registrar's Signature<br>B. Sparks   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ADH

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Animal table with 4 rows

July 13 - 1st 5-6  
July 14 - 2nd 4-5

July 15 - 3rd 3-4  
July 16 - 4th 2-3

July 17 - 5th 1-2  
July 18 - 6th 0-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12297

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ROY JONES</b>  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 9 1999</b>  |  | 3. Time of Death<br><b>16:27 PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL</b>  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>250-20-7943</b>   | 6. Sex<br><b>1</b> M <b>2</b> F   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>7/22/23</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>unk</b>   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |
|   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   |  |  |   |
|   | 10e. Street and Number<br><b>5707 Carter Avenue</b>   |   | 10f. Zip Code<br><b>21214</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |
|   | 11. Marital Status<br><b>unk</b><br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>unk</b><br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>unk</b><br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br><b>unk</b><br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unk</b> College (1-4or 5+) <b>unk</b>                  |  |   |
| To Be Completed by Physician/Medical Examiner   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>unk</b>   |   | 16b. Kind of Business/Industry<br><b>unk</b>   |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ardie Shaw (guardian)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1000 Cathedral Street Baltimore MD 21201</b>         |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>4/14/99 Lansdowne, MD</b>   |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>   |   | 22. Name and Address of Facility<br><b>Albert P. Wylie Funeral Home PA<br/>638 N. Gilmer St. Balto. MD 21217</b>   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  | Approximate Interval Between Onset and Death  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):  |   |   |  |  | <b>1 day</b>  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. MYOCARDIAL ISCHEMIA</b><br>Due to (or as a consequence of):   |   |   |  |  | <b>2 days</b>   |
| <b>c. ASPIRATION</b><br>Due to (or as a consequence of):  |   |   |  |  | <b>4 days</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |  |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 28d. Describe how Injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>N. Dancy, MD</b><br><b>NOUHAD DANCY</b>   |  | 29c. License number<br><b>P11902</b>   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 13, 1999</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GOOD SAMARITAN HOSPITAL 5601 LOCKRAVEN BLVD 21229</b>  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#8 perFH G770 4/14/99 EW

Certificate of Death

Reg. No. 99 12298

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Cynthia Belinda Jones</b>  |  |   |  | 2. Date of Death<br>Month: <b>April</b> Day: <b>08</b> Year: <b>1999</b>   |                                | 3. Time of Death<br><b>0600</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>6319 Mount Ridge Road</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Catonsville</b>   |                                | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>217-68-5246</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>November 16, 1954</b>                                |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  |  |                                |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Catonsville</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>6319 Mount Ridge Road</b>  |  |   |  | 10f. Zip Code<br><b>21228</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br><b>African American</b>                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>4th</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Receptionist Clerk</b>   |                                | 16b. Kind of Business/Industry<br><b>University Hospital</b>                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William P. Wells</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virginia Holland Wells</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Virginia Wells - mother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>124 W. Franklin St. Baltimore, MD 21201</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Cathedral</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore Maryland</b>   |                                | 20d. Date<br><b>4/3/99</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Shirley M. Cullen</b>   |  |   |  | 22. Name and Address of Facility<br><b>Wallace Funeral Service<br/>3405 W. Franklin St. Baltimore, MD 21229</b>  |                                |  |  |

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | e. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Acquired Immune Deficiency Syndrome</b><br>Due to (or as a consequence of):<br>c. <b>Human Immunodeficiency Virus Infection</b><br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death |  |
|--|--|--|--|--|--|

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Candida infection of oropharynx and esophagus</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|   |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>George M. Kunz Jr. M.D. Resident</b>  |  |   |  | License number<br><b>P0841</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>04/12/99</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George M. Kunz Jr. M.D. 600 Wolfe Street, Baltimore, MD 21207</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |  |   |  | 32. Registrar's Signature<br><b>B. Sparks</b>  |  |  |  |

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#18 perFH G770 4/14/99 EW

## Certificate of Death

Reg. No.

99 12299

|                                     |  |  |   |                                  |  |
|-------------------------------------|--|--|---|----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EARL W KOLDENEY</b>   |  | 2. Date of Death<br>Month: <b>April</b> Day: <b>9</b> Year: <b>1999</b>   |                                  | 3. Time of Death<br><b>7:46 AM</b>   |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |                                  | 4c. County of Death<br><b>Howard</b>   |
| Funeral<br>Director                 | 5. Social Security Number<br><b>219-05-4570</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  | If Under 1 Year<br>Months: Days: | If Under 24 Hrs.<br>Hours: Min.  |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>May 7, 1918</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                  |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent  |  | 10a. State<br><b>Maryland</b>   |                                  | 10b. County<br><b>Howard</b>   |
|                                     | 10c. City, Town or Location<br><b>Ellicott City</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                  |  |
|                                     | 10e. Street and Number<br><b>4724-706 Dorsey Hall Drive</b>  |  | 10f. Zip Code<br><b>21042</b>   |                                  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944</b>   |                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer Technician</b>  |
|                                     | 16b. Kind of Business/Industry<br><b>Physics Lab</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Charles A. Schmidt</b>  |                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>"Unknown" Mary E. Berger</b>   |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ms. Zan Lynn Koldewey Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5774 Thunder Hill Road Columbia, Maryland 21045</b>   |                                  |  |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |                                  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |
|                                     | 20d. Date<br><b>04/13/99</b>   |  | 21. Signature of Funeral Service Licensee<br><b>[Signature] MO0535</b>  |                                  |  |
|                                     | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21043</b>   |  |   |                                  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. Metastatic Squamous Cell Ca</b><br>Due to (or as a consequence of):<br><b>c. Diabetes mellitus</b><br>Due to (or as a consequence of):<br><b>d. coronary disease</b> |  |   |                                  | Approximate Interval Between Onset and Death<br><b>1 hour</b><br><b>2 weeks</b><br><b>years</b><br><b>years</b>  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>prostate cancer, previous<br/>cerebrovascular accident</b>  |  |   |                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |                                  | 28b. Time of Injury<br><b>M</b>  |
|                                     | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                  |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                  |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                     |  |   |                                  |  |
|                                     | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>D31172</b>  |                                  | 29d. Date signed (Month, Day, Year)<br><b>April 9 1999</b>   |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H.A. O'Connell 3460 Ellicott Center Dr 103 Ellicott City MD 21043</b>   |  |   |                                  |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



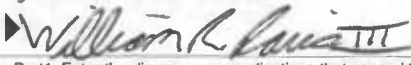
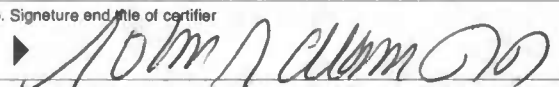

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12300

|  |   |   |  |   |  |   |  |   |                                   |  |
|--|---|---|--|---|--|---|--|---|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM G. KOUWENHOVEN</b>               |   |  |   |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 10 1999</b> |   | 3. Time of Death<br><b>4:00am</b> |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>17 MIDVALE RD.</b> |   |  |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>N/A</b> |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-24-5396</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs. |   | If Under 1 Year<br>Months Days                             |   | If Under 24 Hrs.<br>Hours Min.    |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 08, 1925</b>                            |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                |   | Usual Residence of Decedent                      |   | 10a. State<br><b>MD</b>                                    |   | 10b. County<br><b>N/A</b>         |  |
| 10c. City, Town or Location<br><b>BALTIMORE</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>17 MIDVALE RD.</b>   |  | 10f. Zip Code<br><b>21210</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |                                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+) <b>5+</b>   |                                   |  |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MANAGEMENT CONSULTANT</b>   |   | 16b. Kind of Business/Industry<br><b>MANAGEMENT CONSULTING</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM B. KOUWENHOVEN</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ABIGAIL REMSEN</b>  |  | 19. Informant's Name/Relationship (Type, Print)<br><b>ALEXANDRA S. KOUWENHOVEN (WIFE) 17 MIDVALE RD. BALTO., MD. 21210.</b>   |                                   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CREMATORY</b>  |  | 20c. Date<br><b>04/12/99</b>  |  | 20d. Location - City or Town, State<br><b>BALTO., MD.</b>   |  | 21. Signature of Funeral Service Licensee<br>   |                                   |  |
| 22. Name and Address of Facility<br><b>HENRY W. JENKINS &amp; SONS CO.<br/>4905 YORK RD. BALTO., MD. 21212.</b>  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br><b>b. Smoking</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>10 months</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |                                   |  |
| 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D07259</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/12/99</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOHN J. MANN M.D. 10755 FALLS RD. TIMONIUM MD. 21093.</b>  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 13 1999</b>  |   | 32. Registrar's Signature<br>   |  | 33. State Registrar   |  | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020   |  | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once. |                                   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12301

Lomax, Edna died @ 12:01 AM on 12 APR 99

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>EDNA MAY LOMAX  |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br>April 12, 1999                                 |  | 3. Time of Death<br>12:01 AM   |  |
| 4a. Facility Name (If not institution, give street and number)<br>Hospice of Baltimore Gilchrist Center   |  |   |  |  |  | 4b. City, Town, or Location of Death<br>Towson                                       |  | 4c. County of Death<br>Baltimore   |  |
| 5. Social Security Number<br>212-01-3470  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>83 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 31, 1915                                 |  | 9. Birthplace (State or Foreign Country)<br>Md.  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |
| 10a. State<br>Md.   |  | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Baltimore   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br>4100 Chardel Rd. 3-B  |  |   |  | 10f. Zip Code<br>21236   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary   |  |  | 16b. Kind of Business/Industry<br>Briddell Ins. Co.              |  |  |
| 17. Father's Name (First, Middle, Last)<br>William Wollslager   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Denmeade              |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Paul Moran/nephew   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4100 Chardel Rd. 3-B Baltimore, Md. 21236   |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.  |  | 20c. Location - City or Town, State<br>4/16/99 Towson, Md.                           |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. colon cancer<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>2 1/2 years |  |   |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |  |   |  |  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |  |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D25265  |  | 29d. Date signed (Month, Day, Year)<br>April 12, 1999                                |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>WATLEY GENE 6701 N. Chiles St. Balt. Md 21204   |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 14 1999  |  | 32. Registrar's Signature<br>   |  |  |  |  |  |  |  |

State  
Registrar





jhm  
MELBA

MOORE ITEMS: #23 PART I, 27 PER MEO G770 4-28-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12302

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Melba Garnet Moore

2. Date of Death

Month Day Year  
APRIL 05, 1999

3. Time of Death

01:00 PM

4a. Facility Name (If not institution, give street and number)

10844 DOWNSVILLE PIKE

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

WASHINGTON

5. Social Security Number

Unknown

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 22, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10844 DownsVille Pike

10f. Zip Code

21740

10g. Citizen of What Country?

Canadian

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Otis Butler

18. Mother's Name (First, Middle, Maiden Surname)

Garnet (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Rhonda Jean McMaster -daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

143 Lakeside Dr., Dryden, On. Canada

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Washington Crm.

Date

4/13/99

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc  
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

INANITION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

APRIL 07, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagan, Dr. Karen M.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12303**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rose Lillian Mooney

2. Date of Death

Month Day Year  
April 11 1999

3. Time of Death

12:30 pm

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-09-2912

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 28, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Jacob

18. Mother's Name (First, Middle, Maiden Surname)

Mary Virginia Jackson

19a. Informant's Name/Relationship (Type, Print)

Franklin E. Mooney/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8671 Ridge Road Ellicott City, Md. 21043

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Mem. Gds. 4/15/99

Data

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1050 York Road

Ruck Towson Funeral Home, Inc. Towson, Md. 21204

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No

25. Was case referred to medical

examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 15504

29d. Date signed (Month, Day, Year)

4. 12. 98.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

State  
Registrar

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

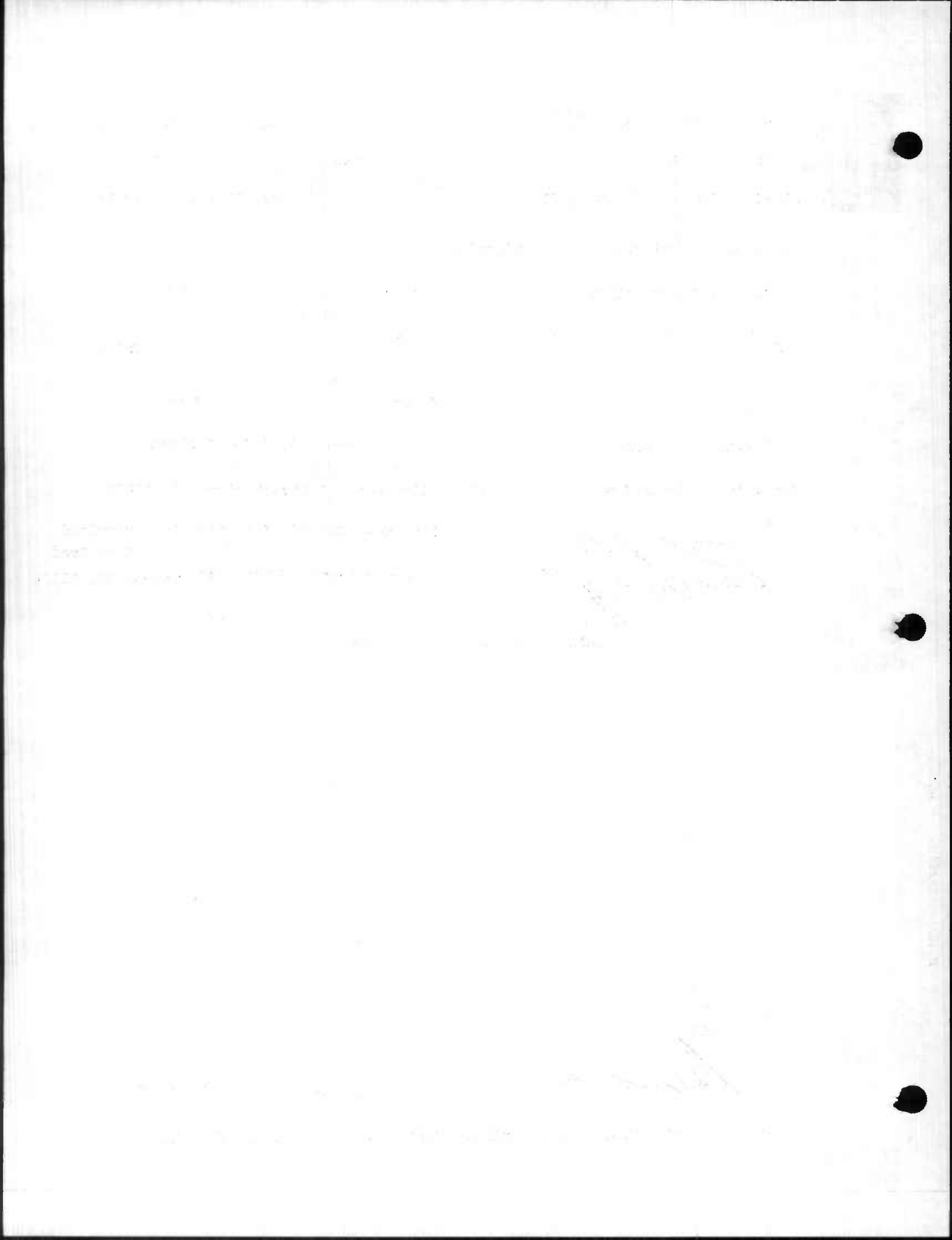
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME: MOONEY, ROSE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12304

Certificate of Death

Reg. No.

|  |   |  |  |   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
|--|---|--|--|---|--|---|---|---|----|-----------|--|----|--------|---------|----|-----------------------|---------|----|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>N A McGee                                       |  |  |   | 2. Date of Death<br>Month Day Year<br>April 9 1999     |   | 3. Time of Death<br>7:21 PM                     |   |    |           |  |    |        |         |    |                       |         |    |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Maryland General Hospital |  |  |   | 4b. City, Town, or Location of Death<br>Baltimore City |   | 4c. County of Death<br>NA                       |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-34-0362  |  | 6. Sex<br>X M 2 F                            |   | 7. Age (in yrs. last birthday)<br>62 Yrs.              |   | 8. Date of Birth (Month, Day, Year)<br>06-13-36 |   |    |           |  |    |        |         |    |                       |         |    |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>SC  |  | 10. Usual Residence of Decedent              |   | 10a. State<br>MD                                       |   | 10b. County<br>NA                               |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 10c. City, Town or Location<br>Baltimore   |   | 10d. Inside City Limits<br>1 X Yes 2 No  |  | 10e. Street and Number<br>430 N. Luzerne Avenue   |  | 10f. Zip Code<br>21224  |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 10g. Citizen of What Country?<br>USA   |   | 11. Marital Status<br>X X Never Married 2 Married<br>3 Widowed 4 Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 Yes 2 No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 Yes 2 No Specify: |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th Grade<br>College (1-4or 5+) NA       |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer                         |  | 16b. Kind of Business/Industry<br>various trades  |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 17. Father's Name (First, Middle, Last)<br>I N Scott   |   |  |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br>Ellen McGee   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Dorothy Williams   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>430 N. Luzerne Avenue Baltimore, MD. 21224 |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 20a. Method of Disposition<br>1 X Burial 2 Cremation 3 Removal from State<br>4 Donation 5 Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Voshell Mem. Gardens   |  | Date<br>04-15-99  |  | 20c. Location - City or Town, State<br>Dundalk, MD  |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 21. Signature of Funeral Service Licensee<br>Dorothy Williams  |   |  |  | 22. Name and Address of Facility<br>Baltimore, Maryland 21202<br>WM.C.March FH 1101 E. North Avenue   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |  |   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Pneumonia</td> <td>Approximate interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Sepsis</td> <td>UNKNOWN</td> </tr> <tr> <td>c.</td> <td>Carcinoma of the Lung</td> <td>UNKNOWN</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |   |  |  |   |  |   |   | Immediate Cause (Final disease or condition resulting in death) | a. | Pneumonia | Approximate interval Between Onset and Death | b. | Sepsis | UNKNOWN | c. | Carcinoma of the Lung | UNKNOWN | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)  | a.  | Pneumonia  | Approximate interval Between Onset and Death |   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
|  | b.  | Sepsis   | UNKNOWN                                      |   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
|  | c.  | Carcinoma of the Lung  | UNKNOWN                                      |   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
|  | d.  |  |  |   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 Yes 2 No 3 Probably 4 X Unknown   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 24a. Was an autopsy performed?<br>1 Yes 2 X No   |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 Yes 2 No   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 25. Was case referred to medical examiner?<br>1 Yes 2 X No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) |  |   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 27. Manner of Death<br>1 X Natural 5 Pending Investigation<br>2 Accident 6 Could not be determined<br>3 Suicide 4 Homicide   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 Yes 2 No  |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 29a. Certifier (Check only one)<br>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                      |   |  |  |   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 29b. Signature and title of certifier<br>R. Meese  |   |  |  | 29c. License number<br>89320  |  | 29d. Date signed (Month, Day, Year)<br>April 9/99   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. Rashad Morad c/o Maryland General Hospital   |   |  |  |   |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 14 1999   |   |  |  | 32. Registrar's Signature<br>B. Sparks  |  |   |   |   |    |           |  |    |        |         |    |                       |         |    |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12305

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Joseph McGuire

2. Date of Death

April 10, 1999 7:27 AM

3. Time of Death

7:27 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

189-03-4240

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 26 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4102 Chardel Rd. unit 1-G

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Credit manager

16b. Kind of Business/Industry

Revere Copper + Brass

17. Father's Name (First, Middle, Last)

Edward McGuire

18. Mother's Name (First, Middle, Maiden Summa)

Agnes Ruddy

19a. Informant's Name/Relationship (Type, Print)

Gloria L. McGuire - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4102 Chardel Rd unit 1-G Perry Hall, Md 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park

Date

April 14 1999

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Keisha S. Wells

22. Name and Address of Facility

Evans Funeral Chapel  
8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. A. H. Philadi

29c. License number

D-12849

29d. Date signed (Month, Day, Year)

4-11-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. A. H. Philadi 7600 Osler Dr. Suite 111 Towson, Maryland

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

Benjamin B. Spaulding

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Edward McGuire

rem





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 9 per F.H.G. 700 4/14/99 reb

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12306

ITEMS: #23 PART I, 27 PER MEO G771 5-19-99 WR.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JESSICA MARIA MARTINEZ

2. Date of Death

April 6, 1999

3. Time of Death

10:55 P.M.

4a. Facility Name (If not Institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-51-9248

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

1

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 24, 1998

9. Birthplace (State or Foreign Country)

U.S.A. MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1419 GUSRYAN STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify

PUERTO RICAN

14. Race - American Indian, Black, White, etc.

Specify  
PUERTO RICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

EDUARDO MARTINEZ

18. Mother's Name (First, Middle, Maiden Surname)

ALICIA TORRES

19a. Informant's Name/Relationship (Type, Print)

EDUARDO MARTINEZ/FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1419 GUSRYAN STREET, BALTIMORE, MARYLAND 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAK LAWN CEMETERY

Date

4/13/99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY & ZEILER INC. FUNERAL HOME  
1901 EASTERN AVENUE, BALTIMORE, MD. 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PULMONARY HYPOPLASIA

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12307

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carroll Lee McKenna, Sr.

2. Date of Death

APRIL 10<sup>th</sup> 1999

3. Time of Death

2:30PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

217-01-6377

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 10, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4-C Silver Leaf Court

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Manager

16b. Kind of Business/Industry

United Insurance Company

17. Father's Name (First, Middle, Last)

William James McKenna

18. Mother's Name (First, Middle, Maiden Surname)

Edith Mary Saunbeck

19a. Informant's Name/Relationship (Type, Print)

Mrs. Shirley McKenna/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4-C Silver Leaf Court Cockeysville, MD. 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

4-13-99

20c. Location - City or Town, State

Parkville, MD.

21. Signature of Funeral Service Licensee

*Michael J. Such...*

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7d.

b. TOTAL GASTRECTOMY

Due to (or as a consequence of):

10d

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. BLEEDING GASTRIC ULCERS

Due to (or as a consequence of):

14d.

d. GASTRIC LYMPHOMA

6wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PANCYTOPENIA.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

*John B. Richardson MD*

29c. License number

D18442

29d. Date signed (Month, Day, Year)

4/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN B. RICHARDSON 1205 YORK RD #22 LUTHERVILLE, MD 21093

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

*Benita B. Smith*

State  
Registrar

McKenna

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

5x1  
R27



jhm

JOHN ALLEN

NELSON ITEMS: #23 PART I, 27, 28A-F PER MEO G770 4-20-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

WR

Certificate of Death

Reg. No.

99 12308

Physician  
/Medical  
Examiner

John Allen Nelson

2. Date of Death  
Month Day Year  
APRIL 04, 1999  
3. Time of Death  
10:15 AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

4780 ALLGATE GREEN

4b. City, Town, or Location of Death

Arbutus

4c. County of Death

BALTIMORE

5. Social Security Number  
212-04-59036. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
21 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
March 1, 19789. Birthplace (State or Foreign  
Country)  
Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4780 Aldgate Green Ct.

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

"N/A"

16b. Kind of Business/Industry

"N/A"

17. Father's Name (First, Middle, Last)

Robert Jennings Nelson

18. Mother's Name (First, Middle, Maiden Surname)

Sherry Ann Lowry

19a. Informant's Name/Relationship (Type, Print)

Ms. Sherry Nelson Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6104 Adcock Lane Hanover, Maryland 21076

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Crest Lawn Memorial Gardens

Date

04/09/99

20c. Location - City or Town, State

Marriottsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

{

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☒ Could not be  
3 ☐ Suicide determined  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)  
Found:  
4-4-9928b. Time of  
Injury  
Found:  
9:3028c. Injury at  
Work?  
1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)  
FOUND AT HOME28f. Location (Street and Number or Rural Route Number,  
City or Town, State) 4780 ALLGATE GREEN,  
BALTIMORE COUNTY, MD.29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

APRIL 05, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12309

|  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>FRANK OAKLEY</b>                    |   |  |  | 2. Date of Death<br>Month <b>4</b> Day <b>4</b> Year <b>99</b> |   | 3. Time of Death<br><b>7:30 PM</b>   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>LEVINDALE</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>       |   | 4c. County of Death<br><b>Baltimore City</b>   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-28-2482</b>                                    |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.               |   | 8. Date of Birth (Month, Day, Year)<br><b>January 4, 1927</b>                                  |  |  |
|  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore City</b>                                       |  | 10c. City, Town or Location<br><b>Baltimore</b>                |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| Usual Residence of Decedent  |  |   |  | 10e. Street and Number<br><b>2434 W. Belevedere Avenue</b>   |  | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1945 1946</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Drywall Finisher</b>   |  | 16b. Kind of Business/Industry<br><b>Construction</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Henry Oakley</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Judd</b>   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Eileen D. Shields Executrix</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 21 Simpsonville, Maryland 21150</b>   |  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park, Inc.</b>  |  | 20c. Date<br><b>04/07/99</b>   |  | 20d. Location - City or Town, State<br><b>Elkridge, Maryland</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br> <b>MO0535</b>  |  |   |  | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21043</b>   |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 Year</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>END STAGE RENAL FAILURE</b>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>DS0164</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/5/99</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mathews, Liji MD 25 Main St., Suite 200 Reisterstown, MD 21136</b>  |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |  | 32. Registrar's Signature<br>  |  |  |  |   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12310

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles John Prescimone, Sr.

2. Date of Death

April 10, 1999

3. Time of Death

11:43am

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-16-9245

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/13/1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2403 Beechland Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Barber

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Frank Prescimone

18. Mother's Name (First, Middle, Maiden Surname)

Frances Maida

19a. Informant's Name/Relationship (Type, Print)

Antoinette L. Prescimone/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2403 Beechland Ave., Baltimore, Maryland 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

04/13/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Christina L. David

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road, Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Congestive Heart Failure

Due to (or as a consequence of):

b. Severe Atherosclerotic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Nestor Carmona, M.D.

29c. License number

D0013649

29d. Date signed (Month, Day, Year)

4/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NESTOR CARMONA, M.D. 6012 HARFORD RD., BALTO, Md. 21214

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

Nestor Carmona

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12311

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FLORENCE MARGARET RAAB

2. Date of Death

Month Day Year  
APRIL 12, 1999

3. Time of Death

11:00 AM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS NURSING CENTER

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-32-5840

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

8/06/02

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

MILLERSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8280 AHEARN DRIVE

10f. Zip Code

21108

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7TH GRADE

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SAMUEL EMGE

18. Mother's Name (First, Middle, Maiden Surname)

AMANDA FRANCIS

19a. Informant's Name/Relationship (Type, Print)

DOLORES WALTON DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8280 AHEARN DRIVE MILLERSVILLE, MD 21108

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

4/15/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

*Leatha N. Hays*

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Mesenteric Thrombosis

Due to (or as a consequence of):

b. Dementia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Leatha N. Hays*

29c. License number

D 15504

29d. Date signed (Month, Day, Year)

4-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

State  
Registrar

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

*Anna B. Sparks*

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

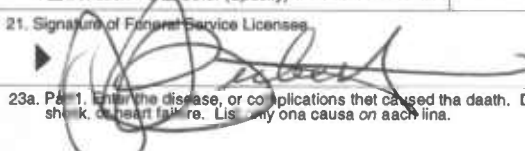
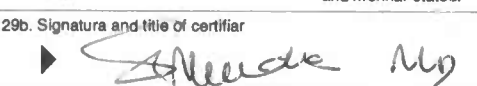



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12312

Certificate of Death

Reg. No.

|  |   |   |   |                                       |  |  |   |  |
|--|---|---|---|---------------------------------------|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>COLLEEN BETTIE ROSTEK</b>  |   |   |                                       | 2. Date of Death<br>Month Day Year<br><b>APRIL 10, 1999</b>  |  | 3. Time of Death<br><b>7:15 AM</b>                                      |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>GENESIS ELDER CARE HAMMONDS LANE</b>   |   |   |                                       | 4b. City, Town, or Location of Death<br><b>BROOKLYN</b>  |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>                              |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-38-7404</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 19, 1942</b>             |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |   | 10a. State<br><b>MARYLAND</b>   |                                       | 10b. County<br><b>ANNE ARUNDEL</b>   |  | 10c. City, Town or Location<br><b>PASADENA</b>                          |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>222 CIRCLE ROAD</b>  |                                       | 10f. Zip Code<br><b>21122</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>AGENT</b>                             |                                       | 16b. Kind of Business/Industry<br><b>REAL ESTATE</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>THOMAS McKEAN</b>   |   |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>GENEVIEVE BETTIE GRIFFIN</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MATTHEW STEVEN ROSTEK (HUSBAND)</b>  |   |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>222 CIRCLE ROAD, PASADENA, MARYLAND 21122</b>  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>MAUSOLEUM</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK</b>   |                                       | 20c. Location - City or Town, State<br><b>4/13/99 GLEN BURNIE, MD.</b>   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |                                       | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>BREAST CANCER</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |                                       |  |  |   | Approximate Interval Between Onset and Death<br><b>2 YEARS</b>   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>STROKE</b>   |   |   |                                       |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |                                       |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                       |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D 21776</b> |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 13 1999</b>                          |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SURYA P. MUNDRA 8109 RITCHIE HWY PASADENA MD 21122</b>  |   |   |   |                                       |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |   | 32. Registrar's Signature<br>   |   |                                       |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, R

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12313

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |                                   |  |
|--|---|--|---|--|--|--|---|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Melvin C. Roppelt, Sr.</i>   |  |   |  | 2. Date of Death<br>Month <i>April</i> Day <i>8</i> Year <i>1999</i>   |  | 3. Time of Death<br><i>1:30pm</i>                                       |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Stella Maris Hospice</i>   |  |   |  | 4b. City, Town, or Location of Death<br><i>Timonium</i>  |  | 4c. County of Death<br><i>Baltimore</i>                                 |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>218-05-0755</i>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>79</i> Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | 8. Date of Birth (Month, Day, Year)<br><i>Feb 17, 1920</i>                                     | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>             |                                   |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |   |                                   |  |
| To Be Completed by Funeral Director  | 10a. State<br><i>Md</i>   | 10b. County<br><i>Baltimore</i>  | 10c. City, Town or Location<br><i>Lutherville</i>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |                                   |  |
|  | 10e. Street and Number<br><i>216 Meadowvale Rd.</i>   |  |   | 10f. Zip Code<br><i>21093</i>  |  | 10g. Citizen of What Country?<br><i>USA</i>  |   |                                   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>-</i>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>operator</i>                      |  | 16b. Kind of Business/Industry<br><i>Baltimore Glas &amp; Electric</i>   |  |   |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Charles Roppelt</i>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Ada Inkeplein</i>  |  |   |                                   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Dorothy C. Roppelt</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>216 Meadowvale Rd. Lutherville, Md 21093</i>   |  |   |                                   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Dulany Valley Mem. Gard.</i>   |  | 20c. Location - City or Town, State<br><i>Timonium Maryland</i>  |  | 20d. Date<br><i>April 12, 1999</i>                                      |                                   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Krista S. Wells</i>   |  |   |  | 22. Name and Address of Facility<br><i>Evans Funeral Chapel<br/>2325 York Rd. Timonium, Md 21093</i>   |  |   |                                   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Metastatic Colon Carcinoma</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>b.</i> Due to (or as a consequence of):<br><i>c.</i> Due to (or as a consequence of):<br><i>d.</i> |  |   |  |  |  |   |                                   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |  |  |   |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Stella Maris hospice</i> |  |  |   |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)                                     |   | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |  |   |                                   |  |
| 29b. Signature and title of certifier<br><i>D. Ramesh</i>  |   |  |   | 29c. License number<br><i>D30641</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>April 9th 1999</i>                                   |   |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Dr. Ramesh Sabapathi, 200 Back River Neck Rd. Essex, Md.</i>  |   |  |   |  |  |  |   |                                   |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 14 1999</i>  |   |  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12314

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |   |  |  |
|--|---|--|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MILDRED RUTH LLOYD ROACH</b>       |  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>April 9, 1999</b> |   | 3. Time of Death<br><b>5:45 PM</b>                                      |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Edenwald</b> |  |   |  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>      |   | 4c. County of Death<br><b>Baltimore</b>                                 |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-34-2638</b>                                   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 25, 1907</b>                                 |   | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>   |  |
|  | Usual Residence of Decedent   |  |   |  |  | 10a. State<br><b>Md.</b>                                   |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Towson</b> |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  | 10e. Street and Number<br><b>800 Southerly Rd.</b>   |  | 10f. Zip Code<br><b>21286</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>   |   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |  |   | 16b. Kind of Business/Industry<br><b>Elementary Education</b>           |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Edward Lloyd</b>  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura Belle Bull</b>   |  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. William Ronald Roach/son</b>  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>70 Hickory Court Rocky Hill, N.J. 08553</b>  |  |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wiseburg United Methodist</b>  |  |  | Date<br><b>4/15/99</b>                                     |   | 20c. Location - City or Town, State<br><b>White Hall, Md.</b>           |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  |   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>  |  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |   |  |  |  |   |   | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Myo Cardial Infarction</b>   |   |  |   |  |  |  |   |   | <b>1 day</b>   |  |
| Due to (or as a consequence of):<br><b>Athero Sclerotic Disease</b>  |   |  |   |  |  |  |   |   | <b>10 yrs.</b>   |  |
| Due to (or as a consequence of):<br><b>Dementia</b>  |   |  |   |  |  |  |   |   | <b>5 yrs.</b>  |  |
| Due to (or as a consequence of):   |   |  |   |  |  |  |   |   |  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |  |   |  |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D29769</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/9/99</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Marcelino D. Alburne, M.D. 1120 N. Rolling Rd. Baltimore, Md. 21228</b>   |   |  |   |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |   |  | 32. Registrar's Signature<br>   |  |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12315

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carroll Joseph Reilly

2. Date of Death

April 10, 1999

3. Time of Death

9:10pm

4a. Facility Name (If not institution, give street and number)

Perring Parkway Elder Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-12-3612

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12/01/1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2514 Moore Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Photographer

16b. Kind of Business/Industry

Aircraft Manufacturer

17. Father's Name (First, Middle, Last)

James Patrick Reilly

18. Mother's Name (First, Middle, Maiden Surname)

Bridget Ann McDonough

19a. Informant's Name/Relationship (Type, Print)

Nettie May Reilly/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2514 Moore Avenue Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

04/13/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Paul L. Hantbrech, Jr.

22. Name and Address of Facility

Leonard J. Ruck, Inc.  
5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HYPERTENSION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MAE MD

29c. License number

D47945

29d. Date signed (Month, Day, Year)

April 13 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harris Aleem 3007 E. Northern Parkway Baltimore MD 21214

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

Jennifer B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12316

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Theresa H. Snowden

2. Date of Death

Month Day Year  
April 12, 1999

3. Time of Death

2:00 PM

4a. Facility Name (If not institution, give street and number)

200 Orchid Road

4b. City, Town, or Location of Death

Stevensville

4c. County of Death

Queen Anne

Funeral  
Director

5. Social Security Number

216-20-9405

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 23, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

200 Orchid Road

10f. Zip Code

21666

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
3

College (14-or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John P. Kierchner

18. Mother's Name (First, Middle, Maiden Surname)

Emilie M. Kaste

19a. Informant's Name/Relationship (Type, Print)

Theresa A. Cochrane - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

200 Orchid Road, Stevensville, Md. 21666

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holy Cross Cemetery

Date

4/16/99

20c. Location - City or Town, State

Brooklyn Park, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc  
7250 Washington Blvd., Elkridge, Md. 2107523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Alzheimer's  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death6 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D32026

29d. Date signed (Month, Day, Year)

4/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary J. Spruill 2108 Piedmont Drive Choke, MD 21619

State  
Registrar

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
0000.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



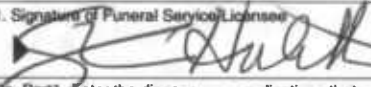


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12317

|   |  |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
|---|--|------------------------------------|---|---|--|---|--------------------------------|--|--|-----------------------------------|---|----|------------------------------|---|----|---------------------------|----|--|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Carolyn Strumsky</b>                              |                                    |   |   | 2. Date of Death<br>Month Day Year<br><b>April 9 1999</b>  |   |                                |  | 3. Time of Death<br><b>10:45 p.m.</b>      |                                   |   |    |                              |   |    |                           |    |  |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7972 W. Riverside Drive</b> |                                    |   |   | 4b. City, Town, or Location of Death<br><b>Pasadena</b>  |   |                                |  | 4c. County of Death<br><b>Anne Arundel</b> |                                   |   |    |                              |   |    |                           |    |  |    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-22-2452</b>  |                                    | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   |   | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.             |                                   |   |    |                              |   |    |                           |    |  |    |  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>August 27, 1926</b>                                    |                                    |   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| Usual Residence of Decedent   |  |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b> |   | 10c. City, Town or Location<br><b>Pasadena</b>  |  |   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 10e. Street and Number<br><b>7972 W. Riverside Drive</b>  |  |                                    |   | 10f. Zip Code<br><b>21122</b>   |  |   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |  |                                    |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Inspector</b>   |  |   |                                | 16b. Kind of Business/Industry<br><b>Westinghouse</b>  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Waldecker</b>   |  |                                    |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Freida Wolf</b>   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John P. Strumsky - son</b>   |  |                                    |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7972 W. Riverside Drive, Pasadena, MD 21122</b> |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                    |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>  |  | Date<br><b>4/13/99</b>  |                                | 20c. Location - City or Town, State<br><b>Elkridge, Maryland</b>                               |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                    |   | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home at Meadowridge Memorial Park Inc<br/>7250 Washington Boulevard, Elkridge, Maryland 21075</b>  |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Myocardial Infarction</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>1 year</b><br/><br/> <b>YRS</b> </td> </tr> <tr> <td>b.</td> <td><b>Chronic Bronchitis</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |                                    |   |   |  |   |                                |  |  |                                   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Myocardial Infarction</b> | Approximate Interval Between Onset and Death<br><br><b>1 year</b><br><br><b>YRS</b> | b. | <b>Chronic Bronchitis</b> | c. |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.   | <b>Myocardial Infarction</b>       | Approximate Interval Between Onset and Death<br><br><b>1 year</b><br><br><b>YRS</b>   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
|   | b.   | <b>Chronic Bronchitis</b>          |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
|   | c.   |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
|   | d.   |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                    |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |                                    |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how injury occurred |   |    |                              |   |    |                           |    |  |    |  |
|   |  |                                    |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 29b. Signature and title of certifier<br>  |  |                                    |   | 29c. License number<br><b>014571</b>  |  |   |                                | 29d. Date signed (Month, Day, Year)<br><b>4/12/99</b>  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CARL T Folkemer 1231 Postal Drive, Pasadena, Md. 21122</b>   |  |                                    |   |   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |  |                                    |   | 32. Registrar's Signature<br>   |  |   |                                |  |  |                                   |   |    |                              |   |    |                           |    |  |    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHHM 16 Rev 6/95

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12318

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harold Moody Scarborough

2. Date of Death

Month Day Year  
APRIL 12 1999 9:18 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

410-42-0021

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 17, 1931

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Linthicum

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

207 Mountain Road

10f. Zip Code

21090

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Marble Mason

16b. Kind of Business/Industry

Bricklayer's Union # One

17. Father's Name (First, Middle, Last)

James Leslie Scarborough

18. Mother's Name (First, Middle, Maiden Surname)

Ressie Poteet

19a. Informant's Name/Relationship (Type, Print)

M. Alice Scarborough (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

207 Mountain Road Linthicum, Maryland 21090

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

Date

4/16/99

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Due to (or as a consequence of):

b. RESPIRATORY FAILURE

Due to (or as a consequence of):

c. RENAL FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

CARCINOMA OF SIGMOID COLON

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Signature of Physician

HOUSE PHYSICIAN, M.D.

29c. License number  
D 51664

29d. Date signed (Month, Day, Year)

APRIL 12 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

Signature of Registrar

21061

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HAROLD SCARBOROUGH

1041 1999



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State of Maryland / Department of Health and Mental Hygiene

Item 17 Per FH FilmG770 4-19-99 rja

## Certificate of Death

Reg. No.

99 12319

Physician  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES MICHAEL SCARANO</b>  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 12, 1999</b>   |   | 3. Time of Death<br><b>5:40 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>213 OAK DRIVE</b>  |  |   | 4b. City, Town, or Location of Death<br><b>PASADENA</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |
| 5. Social Security Number<br><b>577-18-1398</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 17, 1919</b>   | 9. Birthplace (State or Foreign Country)<br><b>MASSACHUSETTS</b>   |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ANNE ARUNDEL</b>  |   | 10c. City, Town or Location<br><b>PASADENA</b>   |  |
| 10e. Street and Number<br><b>213 OAK DRIVE</b>  |  | 10f. Zip Code<br><b>21122</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4or 5+) <b>STATIONARY ENGINEER</b>   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STATIONARY ENGINEER</b>  |   | 16b. Kind of Business/Industry<br><b>B &amp; O RAILROAD</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>MICHAEL Frank F. Scarano</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JANE Jennie Asarisi (UNKNOWN)</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CATHY MOORMAN (DAUGHTER)</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1032 MARTON STREET, LAUREL, MD. 20707</b> |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CENTER LLC. STEVENSVILLE, MD.</b>   |   | 20c. Location - City or Town, State<br><b>4/15/99</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael C. Taffin</i>   |  |   | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>                    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>metastatic carcinoma</i><br>Due to (or as a consequence of):<br>b. <i>of Bladder to Liver and</i><br>Due to (or as a consequence of):<br>c. <i>pelvis</i><br>Due to (or as a consequence of):<br>d. <i>severe ischemic heart disease</i> |  |   |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Edmund S. Clem</i>  |  | 29c. License number<br><b>D19171</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4-13-99</b>  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>795 Argonaut Road Glen Burnie, Md 21061</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |  | 32. Registrar's Signature<br><i>James B. Taffin</i>   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12320

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |   |  |  |
|---|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Alfonzo Stokes</b>                            |   |  |  | 2. Date of Death<br>Month Day Year<br><b>April 11, 99</b> |   | 3. Time of Death<br><b>8:30pm</b>                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>824 Argonne Drive Apt. "G"</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>NA</b>                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-60-3761</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs.          |   | 8. Date of Birth (Month, Day, Year)<br><b>08-04-53</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>                                  |   | 10c. City, Town or Location<br><b>Baltimore</b>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>824 Argonne Drive "G"</b>  |  | 10f. Zip Code<br><b>21218</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th Grade</b><br>College (14 or 5+) <b>NA</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Food Service</b>  |  | 16b. Kind of Business/Industry<br><b>Food Dept.</b>  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alfonzie Stokes</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ernestine Rivers</b>   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean Stokes-Watson</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21216 2316 Allendale Road Baltimore, Maryland</b>   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Western Star Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>04-16-99 Catonsville, MD</b>   |   |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Bernard D. Johnson</b>  |   |   |  | 22. Name and Address of Facility <b>Baltimore, Maryland 21202</b><br><b>WM.C. March FH 1101 E. North Avenue</b>  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Retroviral Infection</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cirrhosis of Liver</b>   |   |   |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>M.D.</b>  |   |   |  | 29c. License number<br><b>D51767</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 14, 1999</b>                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Gregory Lucas, MD. Johns Hopkins Hospital 600 N. Wolfe Street</b>  |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |   |   |  | 32. Registrar's Signature<br><b>B. Spaul</b>   |   |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12321

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES SMITH

2. Date of Death  
Month Day Year

APRIL 10 1999

3. Time of Death

14:47

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

465-16-5648

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02-12-14

9. Birthplace (State or Foreign Country)

TX.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

706 Beaumont Avenue

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th Grade

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Local Union #194

17. Father's Name (First, Middle, Last)

George Smith

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Womack

19a. Informant's Name/Relationship (Type, Print)

Rossetta Derr

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

706 Beaumont Avenue Baltimore, Maryland

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem. 04-16-99 Owings Mills,

Date

20c. Location - City or Town, State

MD

21. Signature of Funeral Service Licensee

Vanessa

22. Name and Address of Facility

Baltimore, Maryland 21202  
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS.  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

P-12564

29d. Date signed (Month, Day, Year)

APRIL 10th 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ELIZABETH T.N. NGUYEN

GOOD SAMARITAN HOSPITAL

BALTIMORE, MD, 21239

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carey W. Smith

2. Date of Death

Month

Day

Year

APRIL 10 1999

3. Time of Death

11:20 PM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

NA

5. Social Security Number

216-52-7474

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

46

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

09-17-52

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

2117 Orleans Street

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 X Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Janitorial

16b. Kind of Business/Industry

Janitorial Service

17. Father's Name (First, Middle, Last)

James Carey Smith

18. Mother's Name (First, Middle, Maiden Surname)

Doris Blackston

19a. Informant's Name/Relationship (Type, Print)

Doris Arrington

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21231  
2117 Orleans Street Baltimore, Maryland

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Western Star Cemetery

Date

04-17-99

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Doris Blackston

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Carcinoma of Tongue

Due to (or as a consequence of):

Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending Investigation

6 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et

Work?

1 Yes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician:

2 Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jose Garcia, M.D.

29c. License number

P12670

29d. Date signed (Month, Day, Year)

4/10/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jose Garcia, M.D. 90 Maryland General Hospital

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12323

|   |  |  |   |   |   |  |  |  |  |
|---|--|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Madeline S. Stanmore</i>                              |  |   |   | 2. Date of Death<br>Month Day Year<br><i>April 12 1999</i>  |  | 3. Time of Death<br><i>9:00 AM</i>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>200 Gardenridge Rd., Apt. A</i> |  |   |   | 4b. City, Town, or Location of Death<br><i>Catonsville</i>  |  | 4c. County of Death<br><i>Baltimore</i>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>579-32-3168</i>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><i>74</i> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><i>Nov. 5 1924</i>  |  |  |
|   | 10a. State<br><i>MD</i>  |  | 10b. County<br><i>Baltimore</i>   |   | 10c. City, Town or Location<br><i>Catonsville</i>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><i>200 Gardenridge Rd., Apt. A</i>  |  |  |   | 10f. Zip Code<br><i>21228</i>   |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>black</i>                            |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+   |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>adult educator</i>  |   | 16b. Kind of Business/Industry<br><i>adult education</i>                               |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Crawley Smith</i>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Margaret Riley</i>  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Margaret Brack, daughter</i>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4809 Wilkens Ave., Baltimore, Md. 21228</i>   |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Baltimore/Washington Crem.</i>   |   | 20c. Location - City or Town, State<br><i>Laurel, Md.</i>                              |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Jane L. Lemmer</i>  |  |  |   | 22. Name and Address of Facility<br><i>Witzke Funeral Homes, Inc.<br/>5555 Twin Knolls Rd., Columbia, Md. 21045</i>   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |   |   |   |  |  | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)<br><i>Heart Disease</i>   |  |  |   |   |   |  |  | <i>years</i>   |  |
| Due to (or as a consequence of):<br><i>Diabetes Mellitus</i>  |  |  |   |   |   |  |  | <i>years</i>   |  |
| Due to (or as a consequence of):<br><i>Atherosclerosis</i>  |  |  |   |   |   |  |  | <i>years</i>   |  |
| Due to (or as a consequence of):<br><i>Renal Insufficiency</i>  |  |  |   |   |   |  |  | <i>years</i>   |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension</i><br><i>Proteinuria</i><br><i>Hyperlipidemia</i>   |  |  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   |  |  |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |  |
|   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>J. Stanmore</i>   |  |  |   | 29c. License number<br><i>847595</i>  |   | 29d. Date signed (Month, Day, Year)<br><i>April 12, 1999</i>                           |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Julianne Huefner 1518 Sulphur Spring Rd. Arbutus MD 21227</i>  |  |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 14 1999</i>   |  |  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12324

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ETHEL VIRGINIA SPRIGGS</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 09 1999</b>  |  | 3. Time of Death<br><b>2:28 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| 5. Social Security Number<br><b>212-34-4541</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (th yrs. last birthday)<br><b>60</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB 28, 1938</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>PARKVILLE</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>2425 WOODCROFT ROAD</b>  |  | 10f. Zip Code<br><b>21234</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 YRS.</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>AT HOME</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DONALD D. SPRIGGS</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2425 WOODCROFT ROAD PARKVILLE MARYLAND 21234</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARKWOOD CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>PARKVILLE, MARYLAND</b>   |  | 20d. Date<br><b>APRIL 13 1999</b>   |  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>   |  |
| 22. Name and Address of Facility<br><b>EVANGELICAL OF MEMORIES 8800 HARBOR ROAD PARKVILLE, MARYLAND 21234</b>   |  | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. GANGRENE OF SMALL BOWEL</b><br>Due to (or as a consequence of):<br><b>b. MESENTERIC ARTERY OCCLUSIVE D.S.</b><br>Due to (or as a consequence of):<br><b>c. ARTERIOSCLEROSIS</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>1 wk.</b><br><b>YRS</b><br><b>YRS.</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                      |  |
| 23c. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b><br><b>CORONARY ARTERY DISEASE</b><br><b>CARCINOMA OF BREAST</b> |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>John B. Richardson MD</b>   |  | 29c. License number<br><b>D18442</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/9/99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOHN B RICHARDSON 1205 YORK RD #22 LUTHERVILLE, MD 21093</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12325

## Certificate of Death

Reg. No.

|  |  |                    |  |  |   |   |  |   |
|--|--|--------------------|--|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Thomas SEVERN  |                    |  |  | 2. Date of Death<br>Month Day Year<br>April 12 1999   |   | 3. Time of Death<br>22:15  |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br>Johns Hopkins Bayview Hospital |                    |  |  | 4b. City, Town, or Location of Death<br>Baltimore   |   | 4c. County of Death<br>N/A                                       |   |
| Funeral<br>Director  | 5. Social Security Number<br>213-42-4453   |                    | 6. Sex<br>XX M 20 F  | 7. Age (In yrs. last birthday)<br>53 Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Sept. 11, 1945            | 9. Birthplace (State or Foreign Country)<br>MARYLAND  |
|  | Usual Residence of Decedent  |                    |  |  |   |   |  |   |
| 10a. State<br>MD.  |  | 10b. County<br>N/A |  | 10c. City, Town or Location<br>BALTIMORE   |   |   | 10d. Inside City Limits<br>1X Yes 20 No                          |   |
| 10e. Street and Number<br>2359 BOSTON STREET   |  |                    |  | 10f. Zip Code<br>21224   |   | 10g. Citizen of What Country?<br>U.S.A.   |  |   |
| 11. Marital Status<br>10 Never Married 20 Married<br>30 Widowed 4X Divorced  |  |                    | 12. Was Decedent Ever in U.S. Armed Forces?<br>10 Yes 2X No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>10 Yes 2X No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>4   |  |                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>VENDOR                          |  |   | 16b. Kind of Business/Industry<br>RETAIL  |  |   |
| 17. Father's Name (First, Middle, Last)<br>JOHN EDWARD SEVERN  |  |                    |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>EVELYN C. GODWIN   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>ADAM L. SEVERN/SON   |  |                    |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2723 N. CHARLES STREET, APT. 10, BALTIMORE, MD. 21218 |   |   |  |   |
| 20a. Method of Disposition<br>10 Burial 2X Cremation 30 Removal from State<br>40 Donation 50 Other (Specify)   |  |                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GREENMOUNT CEMETERY  |  | Date<br>4/14/99   |   | 20c. Location - City or Town, State<br>BALTIMORE, MARYLAND       |   |
| 21. Signature of Funeral Service Licensee<br>  |  |                    |  | 22. Name and Address of Facility<br>LILLY & ZEILER INC. FUNERAL HOME<br>1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231                                 |   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Metastatic Squamous Cell Carcinoma<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last |  |                    |  |  |   |   |  | Approximate Interval Between Onset and Death<br>Years                                       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                    |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>10 Yes 20 No 3X Probably 40 Unknown |  |   |
|  |  |                    |  |  |   | 24a. Was an autopsy performed?<br>10 Yes 2X No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>10 Yes 2X No |
| 25. Was case referred to medical examiner?<br>10 Yes 2X No   |  |                    | 26. Place of Death (Check only one)<br>Hospital: 1X Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 60 Other (Specify) |  |   |   |  |   |
| 27. Manner of Death<br>10 Natural 50 Pending Investigation<br>20 Accident 60 Could not be determined<br>30 Suicida<br>40 Homicide  |  |                    | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>10 Yes 20 No                             |   |
|  |  |                    | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   | 28d. Describe how injury occurred   |  |   |
|  |  |                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |   |
| 29a. Certifier (Check only one)<br>1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                    | 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br>98021  |  | 29d. Date signed (Month, Day, Year)<br>April 12 1999  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>I. BROWNER MD Johns Hopkins Bayview Medical Center   |  |                    |  |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br>APR 14 1999   |  |                    | 32. Registrar's Signature<br>  |  |   |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 5 per F.H G-770 4/20/99 reb

Certificate of Death

Reg. No.

99 12326

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

RANDALL

R

SCHUNK

2. Date of Death

April 12 1999

Day

Year

3. Time of Death

10:14AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

281-07-4416

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

8. Date of Birth

April 30 1917

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MO

10b. County

Washington

10c. City, Town or Location

Potosi

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

106 A Windmille Drive

10f. Zip Code

63664

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director of Labor

16b. Kind of Business/Industry

Manufacturing Co.

17. Father's Name (First, Middle, Last)

Adam

Schunk

18. Mother's Name (First, Middle, Maiden Surname)

Sue

Shepherd

19a. Informant's Name/Relationship (Type, Print)

Susan Manning - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

827 South Woodlynn Rd. Baltimore Md 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bellerive Heritage

Date

4/16/99

20c. Location - City or Town, State

Creve Coeur MO

21. Signature of Funeral Service Director

*[Signature]*

22. Name and Address of Facility

Stallings Funeral Home P.A.  
3111 Mountain Road Pasadena, MD 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Fatal Arrhythmia

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Cardiomegaly

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 Months

3 Months

3 Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* Dr. Latonia E. Mack, MD

29c. License number

AF2328412-2100

29d. Date signed (Month, Day, Year)

4/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Latonia Mack 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

*[Signature]* B. Sparks

State  
Registrar

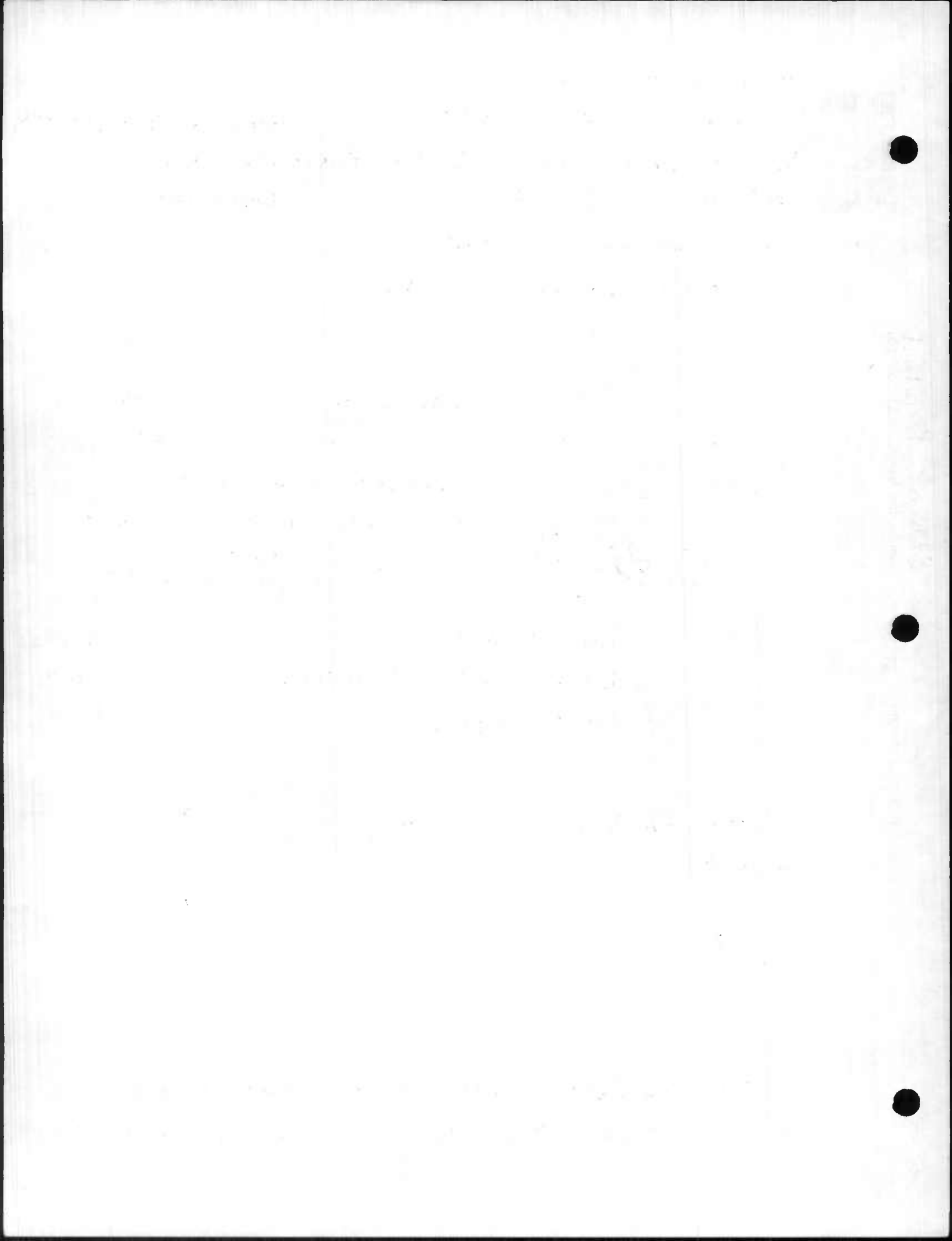
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Schunk, Randall  
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12327

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>Agnes Tydings</i>  |  | 2. Date of Death<br>Month <i>April</i> Day <i>9</i> Year <i>1999</i>  |  | 3. Time of Death<br><i>4 pm</i>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><i>St. Agnes Nursing &amp; Rehab Center</i>   |  | 4b. City, Town, or Location of Death<br><i>Ellicott City</i>  |  | 4c. County of Death<br><i>Howard</i>  |  |
| 5. Social Security Number<br><i>212-74-1787</i>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>92</i> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><i>January 9, 1907</i>   |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>   |  |   |  |
| 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Howard</i>  |  | 10c. City, Town or Location<br><i>Ellicott City</i>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><i>9581 Old Frederick Road</i>  |  | 10f. Zip Code<br><i>21042</i>   |  |
| 10g. Citizen of What Country?<br><i>U.S.A.</i>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>5</i> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Homemaker</i>   |  | 16b. Kind of Business/Industry<br><i>Home</i>   |  |
| 17. Father's Name (First, Middle, Last)<br><i>William Martin Jendraszkiewicz</i>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Agnes Rose Rutkowski</i>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Mr. William Tydings Son</i>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>9581 Old Frederick Road Ellicott City, Maryland 21042</i>   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Lorraine Park Cemetery</i>   |  | 20c. Location - City or Town, State<br><i>Baltimore, Maryland</i>   |  |
| 21. Signature of Funeral Service Licensed<br><i>[Signature]</i> <i>MO0535</i>   |  | 22. Name and Address of Facility<br><i>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21043</i>  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>Respiratory Failure 50 to COPD</i><br>Due to (or as a consequence of):<br><i>HTN</i><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):          |  | Approximate Interval Between Onset and Death<br><i>39 yr.</i><br><i>10 yr.</i>  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><i>M</i>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><i>D 21928</i>   |  |
| 29d. Date signed (Month, Day, Year)<br><i>4/9/99</i>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Dr. Luis Zuniga 1101 Maiden Choice Lane Balto. Md. 21229</i>   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 14 1999</i>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12328

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PERRY

2. Date of Death

Month

Day

Year

TRIMBLE

APRIL

12

1999

03:00

03:00

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE, MD

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

271-12-7922

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 24, 1921

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3412 Ravenwood Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

Mass Transit  
State Government

17. Father's Name (First, Middle, Last)

James Trimble

18. Mother's Name (First, Middle, Maiden Surname)

Verdi Fraizer

19a. Informant's Name/Relationship (Type, Print)

Mrs. Roxie V. Trimble (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3412 Ravenwood Avenue Baltimore, Maryland 21213

20a. Method of Disposition

1 ☒ Burial2 ☐ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

4/15/99

20c. Location - City or Town, State

Brooklyn, Maryland

21. Signature of Funeral Service Licensee

Michael E. Canapp

22. Name and Address of Facility

5305 Harford Road

LEONARD J. RUCK, INC. Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. SMALL CELL LUNG CANCER

2 months

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NEUTROPENIA

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Matthew T. Yeatman, M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

April 12, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MATTHEW T. YEATMAN, M.D.

JOHNS HOPKINS HOSPITAL

BALTIMORE, MD

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural" or item 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

x

x

x

x

^

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12329

|   |   |   |  |  |   |  |  |   |  |
|---|---|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JESSE OWEN VIA</b>   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 12, 1999</b> |  | 3. Time of Death<br><b>3:19 AM</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>       |  | 4c. County of Death<br><b>BALTIMORE</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>228-28-0286</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>5/9/28</b>   | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b> |  |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |   |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>RIDGELEIGH</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>1630 YAKONA ROAD</b>   |   |   |  | 10f. Zip Code<br><b>21286</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1947-1950</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7TH GRADE</b><br>College (1-4or 5+) <b>MECHANIC</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>JARMAN PONTIAC</b>   |   | 16b. Kind of Business/Industry   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>JESSE NASH VIA</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NANNY LOU BRYANT</b>   |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>EUGENIA VIA WIFE</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1630 YAKONA ROAD BALTIMORE, MD 21286</b>   |   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY, INC.</b>  |  | Date<br><b>4/13/99</b>   |   | 20c. Location - City or Town, State<br><b>CATONSVILLE, MD</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Katherine N. Hays</i>   |   |   |  | 22. Name and Address of Facility<br><b>THE JOHNSON FUNERAL HOME, P.A.<br/>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>   |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Ventricular Tachycardia</b><br>Due to (or as a consequence of):<br><b>Acute inferior myocardial infarction</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  | Approximate Interval Between Onset and Death   |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                           |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><i>Michael DO FACA</i>   |  | 29c. License number<br><b>H18792</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/12/99</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6701 N. CHARLES STREET TOWSON, MD 21204</b>  |   |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |   | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

VIA, JESSE

AH(1)+6







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12330

|   |   |  |   |                                   |  |  |  |  |
|---|---|--|---|-----------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Calvin B. Weems, Jr   |  |   |                                   | 2. Date of Death<br>Month Day Year<br>4 9 1999   |  | 3. Time of Death<br>9:30 a.m.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>16 Plater Court   |  |   |                                   | 4b. City, Town, or Location of Death<br>Woodlawn   |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-40-1133  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                   | 7. Age (In yrs. last birthday)<br>54 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>7-21-1944   |  |
|   |   |  |   |                                   |  |  | 9. Birthplace (State or Foreign Country)<br>Md   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |                                   |  |  |  |  |
|   | 10a. State<br>Md  |  | 10b. County<br>Baltimore  |                                   | 10c. City, Town or Location<br>Woodlawn  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br>16 Plater Court   |  |   |                                   | 10f. Zip Code<br>21207   |  | 10g. Citizen of What Country?<br>U S A   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collega (1-4 or 5+)<br>12th grade  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Plant Operator   |                                   | 16b. Kind of Business/Industry<br>W. R. Grace  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br>Calvin B. Weems, Sr  |  |   |                                   | 18. Mother's Name (First, Middle, Maiden Summa)<br>Floretta Bush   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Leslie Weems- Wife  |  |   |                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5 Hopi Court Randallstown, Md 21133   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery   |                                   | 20c. Location - City or Town, State<br>4-14-99 Woodlawn, Md  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |                                   | 22. Name and Address of Facility<br>March F/H West<br>4300 Wabash Avenue Baltimore, Md 21215   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Myocardial Infarction</u><br>Due to (or as a consequence of):<br>b. <u>hypertension</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Diabetes Mellitus</u><br><u>Bronchial Asthma</u>   |  |   |                                   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |   |  |   |                                   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |   |  |   |                                   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                   |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |                                   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28d. Describe how injury occurred |  |  |  |  |
|   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)           |   |                                   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |                                   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  |   | 29c. License number<br>D25112     |  | 29d. Date signed (Month, Day, Year)<br>4/14/1999 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>TAHOORA KAWAJA 1777, Reisterstown Rd #108 Baltimore MD 21208  |   |  |   |                                   |  |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>APR 14 1999  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |                                   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12331

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>GERTRUDE WEST</b>   |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 19 99</b>   |  | 3. Time of Death<br><b>1342</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL Bethesda, Md 20851</b>  |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>577-34-3419</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 8, 1910</b> | 9. Birthplace (State or Foreign Country)<br><b>unknown</b>   |
|   | Usual Residence of Decedent  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>MONTGOMERY</b>  | 10c. City, Town or Location<br><b>Bethesda</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number   |   | 10f. Zip Code  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>unknown</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b><br>College (14 or 5+) <b>unknown</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>unknown</b>  |  | 16b. Kind of Business/Industry<br><b>unknown</b>   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>unknown</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>unknown</b>  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>unknown</b>   |  | 20c. Location - City or Town, State<br><b>unknown</b>  |
|   | 21. Signature of Funeral Service Licenses<br><b>Joseph B. Van Sant</b>   |   | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street, Baltimore, Maryland 21201</b>  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>RESPIRATORY FAILURE.</b><br>Due to (or as a consequence of): <b>Chronic Obstructive Pulmonary Disease</b><br><b>Stroke with resultant Dementia</b><br><b>Seizure Disorder</b><br><b>ETHANOLISM. Since the past</b><br><b>Tobacco Abuse</b> |   |  |  | Approximate Interval Between Onset and Death   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred<br><b>NA</b>   |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                               |   |  |  |  |
|   | 29b. Signature and title of certifier<br><b>Kamalineev Deshpande MD 20415</b>  |   | 29c. License number  |  | 29d. Date signed (Month, Day, Year)<br><b>3. 19. 99</b>  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KAMALINEEV DESHPANDE M.D.</b>   |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |   | 32. Registrar's Signature<br><b>B. Sparks</b>  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12332

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MAY V. WELLER

2. Date of Death

APRIL 12 1999

3. Time of Death

10:30PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HARBOR TAW CONVELESCENT CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

215-22-3400

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 26, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1728 Light Street

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frederick

Kleinsmith

18. Mother's Name (First, Middle, Maiden Surname)

Virginia

Clardy

19a. Informant's Name/Relationship (Type, Print)

Mrs. Viola Patterson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38 E. Barney Street Baltimore, Md. 21230

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

4/16/99

20c. Location - City or Town, State

Brooklyn Park, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

130 East Fort Avenue Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Coronary Artery Disease*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Hyperension*  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Dementia**Recurrent UTIs**Secret Deceit*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

053283

29d. Date signed (Month, Day, Year)

4/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Christopher Isky, 447 South Hanover St Baltimore MD 21230*

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12333

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>BESSIE V. WHITE</b>  |  |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>7th</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>10:00 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Villa Nursing Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Catonsville</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-20-8851</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 18, 1922</b>                                |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Catonsville</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>5920 Moorehead Road</b>  |  | 10f. Zip Code<br><b>21228</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cafeteria Worker</b>  |  | 16b. Kind of Business/Industry<br><b>Howard County School</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Millard J. White</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virgie M. Easterday</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Richard White Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1304 Jervis Square Belcamp, Maryland 21017</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. View Cemetery</b>  |  | 20c. Date<br><b>04/10/99</b>   |  | 20d. Location - City or Town, State<br><b>Marriottsville, MD</b>                            |  |
|  | 21. Signature of Funeral Service Licensee<br> <b>MOOS35</b>   |  |   |  | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21043</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC CARCINOMA OF LUNG</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b>  |  |   |  |  |  |   |  |
|  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |   |  |
| 7  | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D-30469</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 7th 1999</b>                                |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N.B. VELLANKI, 9055, CHEVROLET DRIVE, #100, ELICOTT CITY, MD 21042</b>   |  |   |  |  |  |   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |  | 32. Registrar's Signature<br>  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12334

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROLAND WRIGHT

2. Date of Death

Month  
APRILDay  
11Year  
1999

3. Time of Death

6:20am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

216-32-8496

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 6 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Md

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3010 Woodring Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

self employed

16b. Kind of Business/Industry

R.C. Electric

17. Father's Name (First, Middle, Last)

Jacob H. Wright

18. Mother's Name (First, Middle, Maiden Surname)

Catherine J. Wolf

19a. Informant's Name/Relationship (Type, Print)

Christine Glass

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3001 Christopher Ave. Hamlet, Md 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

April 16 1999

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Evans / G. B. # 121

22. Name and Address of Facility

Evans Funeral Chapel  
8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. PNEUMONIA  
Due to (or as a consequence of):

1 WEEK

c. LUNG CARCINOMA  
Due to (or as a consequence of):

UNCERTAIN.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Evans MD

29c. License number

P12564

29d. Date signed (Month, Day, Year)

APRIL 11 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELIZABETH T. NGUYEN

GOOD SAMARITAN HOSPITAL

21239.

31. Date filed (Month, Day, Year)

APR 14 1999

Registrar's Signature

James B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #5 PER INFORMANT G772 6-19-99 WR.

## Certificate of Death

Reg. No.

99 12335

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Constance Mae Williams

2. Date of Death

Month Day Year  
April 12 1999

3. Time of Death

12:55 PM

4a. Facility Name (If not institution, give street and number)

Manor Care Health Services

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

093-18-5062  
093-19-5062

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAY 15, 1910

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

811 BEAVER BANK CIRCLE

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

(UNKNOWN)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

CHARLES A. CASPER

18. Mother's Name (First, Middle, Maiden Summa)

MARY F. PUTNAM

19a. Informant's Name/Relationship (Type, Print)

DONALD ALLENWALT, PERS. REP.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

805 N. CALVERT ST. BALTIMORE, MD. 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

APRIL 15, 1999

20c. Location - City or Town, State

PARKVILLE, MD.

21. Signature of Funeral Service Licensee

Kenda S. Wells

22. Name and Address of Facility

EVANS CHAPEL OF CHIMES

2325 YORK RD. THONON, MD. 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

probably massive G-I bleeding

Due to (or as a consequence of):

duodenal ulcer

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

minutes  
weekly or  
months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- severe malnutrition

- @ hip decubitus stage IV

- cellulitis - wounds

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

F. K. M. D.

29c. License number

D48271

29d. Date signed (Month, Day, Year)

4-12-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAHED KOULE 7600 Jeter Drive Suite 203 Towson, MD 21204

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

Brenda G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

416

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12336

|   |   |   |  |   |  |  |   |  |
|---|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth Weidenhan</b>                          |   |  |   | 2. Date of Death<br>Month Day Year<br><b>April 11 1999</b> |  | 3. Time of Death<br><b>8:15 AM</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b> |  | 4c. County of Death<br><b>Anne Arundel</b>                  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-30-0775</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>89 Yrs.</b>           |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 13, 1909</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                     |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Anne Arundel</b>                         |  | 10c. City, Town or Location<br><b>Glen Burnie</b>           |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>394 Washington Avenue</b>  |  | 10f. Zip Code<br><b>21061</b>  |   |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dietician</b>                         |  | 16b. Kind of Business/Industry<br><b>Public School</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>August Weidenhan</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Rohlander</b>  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>August L. Haynes - Nephew</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>238 West Meadow Road, Brooklyn Park, MD 21225</b> |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>April 15 Baltimore, Maryland</b>  |  | 20d. Date  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Stallings Funeral Home, P.A.</b>   |  | 22. Name and Address of Facility<br><b>3111 Mountain Road, Pasadena, MD 21122</b>   |  | 22. Name and Address of Facility   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>ATHEROSCLEROTIC HEART DISEASE</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |   |   |  |   |  |  |   |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ANGEMIA, CELLULITIS</b><br><b>HYPERTENSION, PREVIOUS CEREBRO</b><br><b>VASCULAR DISEASE RIGHT HEMIPLEGIA</b>  |   |   |  |   |  |  |   |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |   |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.         |   |   |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D0054288</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL TWELTH 1999</b><br><b>4-12-1999</b>   |  | 29e. Date signed (Month, Day, Year)  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>R. Rangarajan, MD 301 Hospital Drive, Glen Burnie, MD 21061</b>  |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>   |   | 32. Registrar's Signature<br>   |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12337**  
**Certificate of Death**

Reg. No.

|  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Leo R. Yingling</b>                                   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 8, 1999</b> |  | 3. Time of Death<br><b>1350</b>                             |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>                  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-42-3606</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>53</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 18, 1945</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                      |  | 10. Usual Residence of Decedent<br>10a. State <b>PA</b> 10b. County <b>Cumberland</b> 10c. City, Town or Location <b>Mechanicsburg</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 10e. Street and Number<br><b>220 S. York St.</b>           |  | 10f. Zip Code<br><b>17055</b>                               |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                          |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chef</b>   |  | 16b. Kind of Business/Industry<br><b>Restaurant Industry</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Leo Yingling</b>   |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gertrude Troy</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dawn Frampton</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1699 Brice Ct., Crofton, Md. 21114</b>   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Conemaugh, Pa.</b>   |  | 21. Signature of Funeral Service Licensee<br><i>Thomas Guyon</i>   |  | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.<br/>7250 Washington Blvd., Elkridge, Md. 21075</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiac Arrhythmia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | Approximate Interval Between Onset and Death<br><b>24h</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alcohol Withdrawal</b><br><b>Laryngeal Cancer</b> |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |
| 29b. Signature and title of certifier<br><i>Dr. Sh. Physician</i>  |  | 29c. License number<br><b>D47518</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-8-99</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Theresa Buckma AAME Franklin, Catholic St. ANNAPOLIS, MD 21401</b>  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  | State Registrar  |  | DHMH 16 Rev 6/95   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#23a perPhyG7759/2 State of Maryland / Department of Health and Mental Hygiene

99 12338

Amended Item#23a perPhyG755 9/9/99 EW

Certificate of Death

Reg. No.

|  |  |   |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|--|--|---|---|--|---|---|--|---|---|----------------------------------|--|--|--|--|--|---|----------------------------------|--|--|--|--|--|--|--------------------------------|--|--|--|--|--|-----------------|----------------------------------|--|--|--|--|--|--|--|---|--|--|--|--|--|--------------------|----------------------------------|--|--|--|--|--|-----------------|----|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Baby Girl Arter</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>February 4, 1999</b>   |   | 3. Time of Death<br><b>4:01 a.m.</b>   |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>St Agnes Healthcare, 900 S. Caton Ave</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>None</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>February 1, 1999</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | Usual Residence of Decedent  |   |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |   | 10b. County   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | 10e. Street and Number<br><b>1223 Federal St</b>   |   |   |  | 10f. Zip Code<br><b>21202</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>None</b>  |   | 16b. Kind of Business/Industry   |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Tahira Arter</b>  |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>St. Agnes Healthcare</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>900 S. Caton Ave, Baltimore MD 21229</b>  |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St Agnes Healthcare</b>  |  | Date<br><b>4-16-99</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Cathy Berg for R Colgan</b>  |   |   |  | 22. Name and Address of Facility<br><b>St Agnes Healthcare<br/>900 S. Caton Ave, Baltimore, MD 21229</b>  |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">a. <b>Pulmonary hypertension</b></td> <td>Approximate Interval Between Onset and Death<br/><b>3-4 days</b></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="6">b. <b>Hypoxemia + ? sepsis</b></td> <td><b>3-4 days</b></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="6">c. <b>Intrauterine growth retardation</b></td> <td><b>Since Birth</b></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td><b>36 weeks</b></td> </tr> <tr> <td colspan="6">d.</td> <td></td> </tr> </table> |   |   |  |   |   |  |   | Immediate Cause (Final disease or condition resulting in death) | a. <b>Pulmonary hypertension</b> |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>3-4 days</b> | Due to (or as a consequence of): |  |  |  |  |  |  | b. <b>Hypoxemia + ? sepsis</b> |  |  |  |  |  | <b>3-4 days</b> | Due to (or as a consequence of): |  |  |  |  |  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. <b>Intrauterine growth retardation</b> |  |  |  |  |  | <b>Since Birth</b> | Due to (or as a consequence of): |  |  |  |  |  | <b>36 weeks</b> | d. |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  | a. <b>Pulmonary hypertension</b>   |   |   |  |   |   | Approximate Interval Between Onset and Death<br><b>3-4 days</b>  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | Due to (or as a consequence of):   |   |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | b. <b>Hypoxemia + ? sepsis</b>   |   |   |  |   |   | <b>3-4 days</b>  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | Due to (or as a consequence of):   |   |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c. <b>Intrauterine growth retardation</b>  |   |   |  |   |   | <b>Since Birth</b>   |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | Due to (or as a consequence of):   |   |   |  |   |   | <b>36 weeks</b>  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  | d.   |   |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congenital heart disease - interventricular septal defect</b>   |  |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M               |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  |  | 28d. Describe how injury occurred   |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)      |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>William J. Hicken</b>  |  |   |   | 29c. License number<br><b>D04964</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>February 5, 1999</b>                              |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. William J. Hicken - St. Agnes HealthCare - 900 Caton Avenue- Baltimore, MD. /</b>   |  |   |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |   |  |   |   |                                  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                                |  |  |  |  |  |                 |                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |                    |                                  |  |  |  |  |  |                 |    |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12339**  
**Certificate of Death**

Reg. No.

|  |  |   |  |   |   |  |   |  |   |   |  |
|--|--|---|--|---|---|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Paula Alvarez</b>   |   |  |   | 2. Date of Death<br>Month Day Year<br><b>March 26, 1999</b> |  |   |  | 3. Time of Death<br><b>7:45 A.m.</b>                    |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Clinton</b>      |  |   |  | 4c. County of Death<br><b>Prince George's</b>           |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-25-7816</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>March 2, 1930</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Cuba</b> |   |  |
|  | Usual Residence of Decedent  |   |  |   |   |  |   |  |   |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Camp Springs</b>  |   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |
| 10e. Street and Number<br><b>6107 Wesson Dr.</b>   |  |   |  | 10f. Zip Code<br><b>20746</b>   |   |  |   | 10g. Citizen of What Country?<br><b>Cuba</b>   |   |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Cuban</b>   |   |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Hispanic</b>   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   |  |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joaquin Alvarez</b>  |  |   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elvira Paneque</b> |   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Maria Dobarro-Hayag/Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6107 Wesson Dr. Camp Springs, MD 20746</b>  |   |  |   |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Clinton, Md.</b>                 |   | 20d. Date<br><b>3/29/99</b>  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>George P. Kalas</b>  |  |   |  | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home, P.A.<br/>6160 Oxon Hill Rd. Oxon Hill, MD 20745</b>  |   |  |   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. STAPHYLOCOCCAL BACTEREMIA</b><br>Due to (or as a consequence of): <b>PROBABLE MRSA</b><br><br><b>b. PERMACATH</b><br>Due to (or as a consequence of):<br><br><b>c. RENAL FAILURE</b><br>Due to (or as a consequence of):<br><br><b>d. MULTIPLE MYELOMA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last |  |   |  |   |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>3 DAYS</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b>   |  |   |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
|  |  |   |  | 28d. Describe how injury occurred   |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  |
|  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><b>Pamela Guha M.D.</b>  |   |  |   | 29c. License number<br><b>D 16 116</b>   |   |   |  |
|  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>March 26th, 1999</b>  |   |  |   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>PAMELA GUHA M.D., 8926 WOODYARD RD #501 CLINTON MD 20735</b>  |  |   |  |   |   |  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

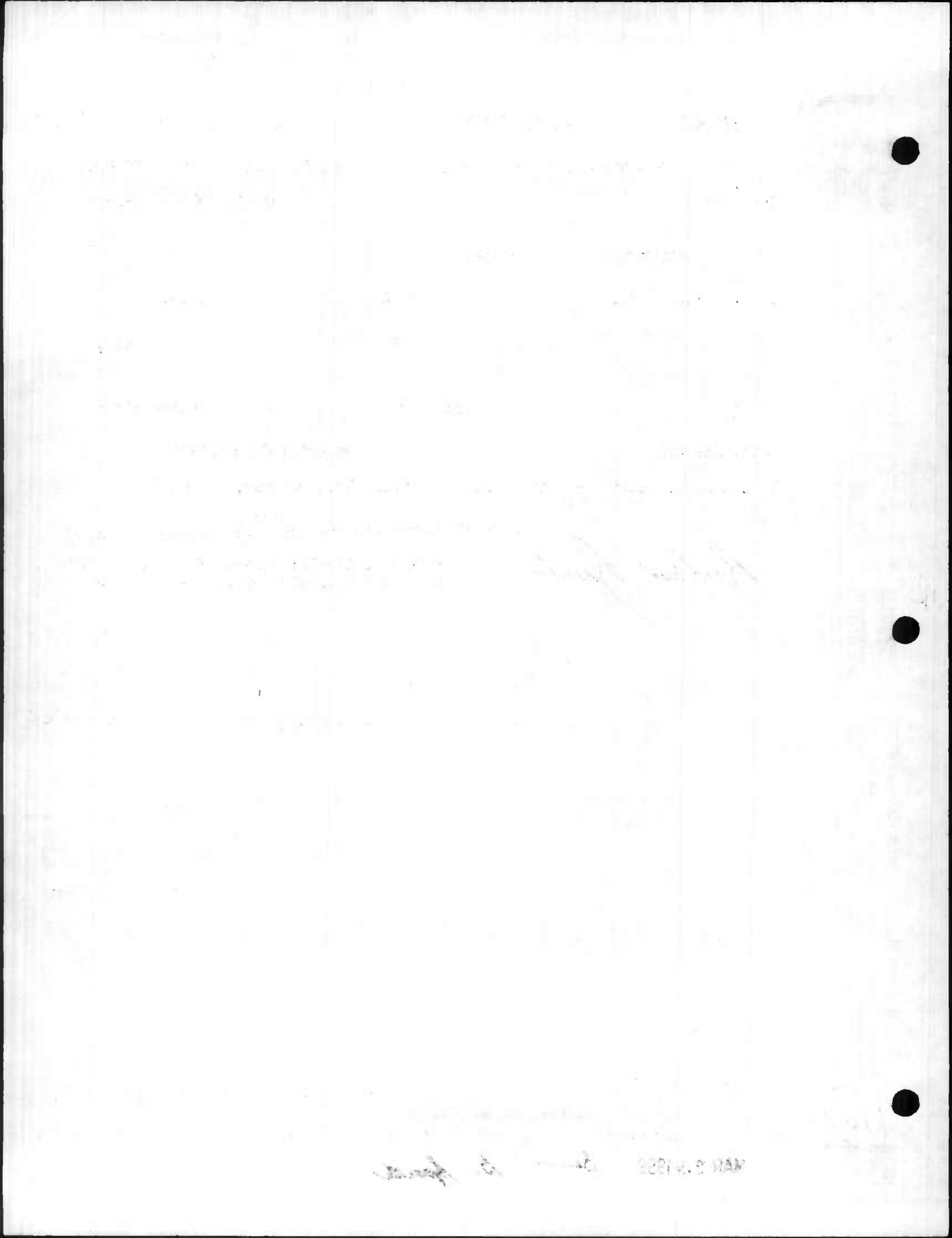
Reg. No.

99 12340

|  |   |   |  |  |  |  |  |   |  |
|--|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HARRY ANESTOS</b>  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 26 1999</b> |  | 3. Time of Death<br><b>9.15 PM.</b>                        |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>                   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>255-03-7369</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>May 21, 1917</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Georgia</b>  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Montgomery</b>                           |  | 10c. City, Town or Location<br><b>Potomac</b>              |   |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>10417 Holbrook Dr.</b>  |  | 10f. Zip Code<br><b>20854</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4or 5+) <b>8</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Attorney</b>  |  | 16b. Kind of Business/Industry<br><b>Self-Employed</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Peter Anestos</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Constantine</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Xanthippe A. Anestos - Wife</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10417 Holbrook Dr. Potomac, MD 20854</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>                   |  |
| 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Philip D. Rinaldi Funeral Service 20904 11818 New Hampshire Ave. Silver Spring, MD</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>SEPSIS</b><br>Due to (or as a consequence of):<br>b. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br>c. <b>RENAL INSUFFICIENCY</b><br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death<br><b>4 DAYS</b><br><b>4 DAYS</b><br><b>2 WEEKS</b>   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><br><b>Atit P. Kuruvilla, M.D.</b>   |  | 29c. License number<br><b>D46187</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 27, 1999.</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Atit P. Kuruvilla, M.D., 1125 ROCKVILLE PIKE, #303, ROCKVILLE, MD 20852</b>   |   | 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  | 32. Registrar's Signature<br>  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

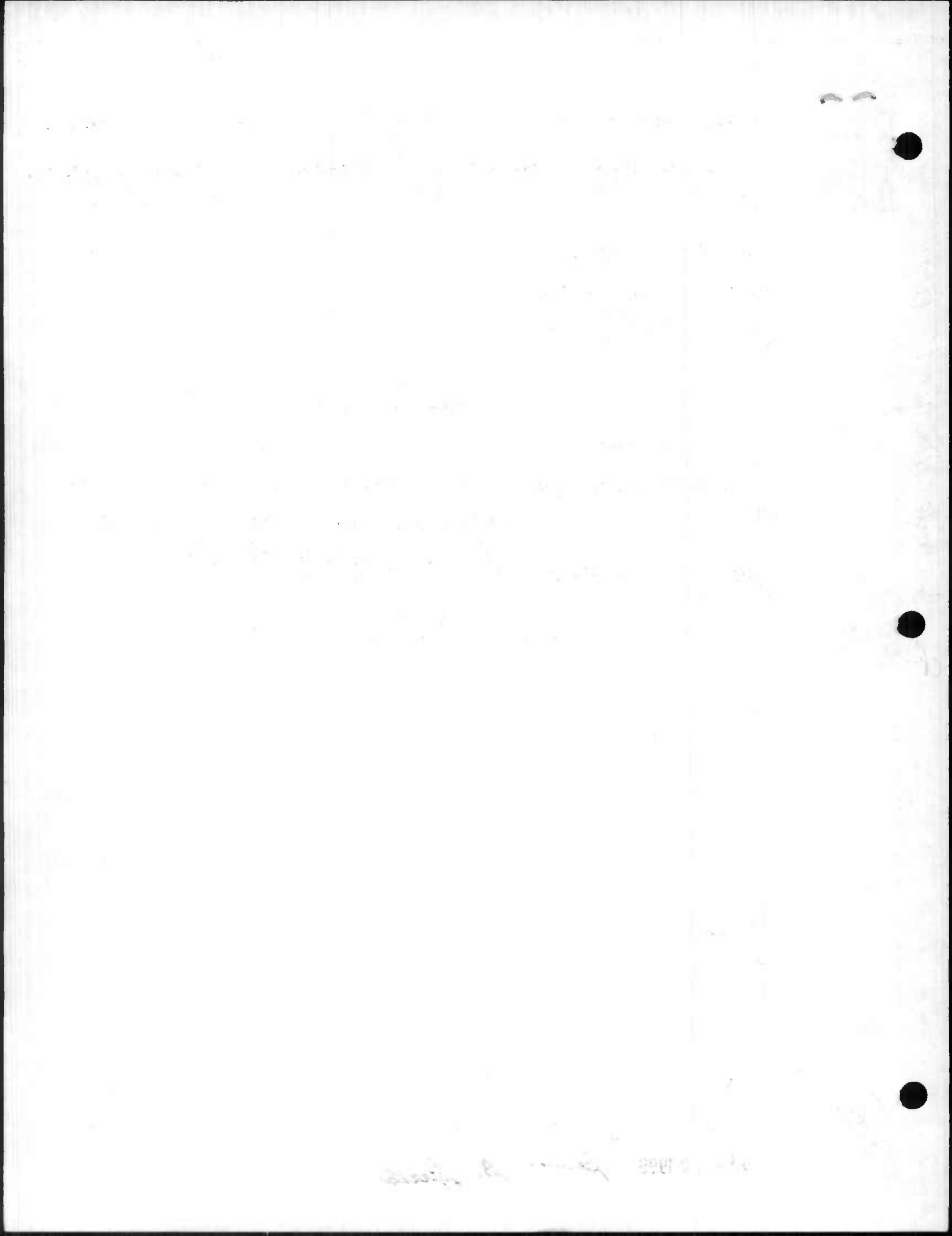
Certificate of Death

Reg. No.

99 12341

|   |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>GERTRUDE MARGARET BUTLER</b>  |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>27</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>3:45pm.</b>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Doctors Community Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>  |  | 4c. County of Death<br><b>Prince George's Co.</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>578-26-3303</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>11-19-13</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>Prince George's</b>  |  | 10c. City, Town or Location<br><b>Mitchellville</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>11411 Lake Arbor Way #210</b>   |  | 10f. Zip Code<br><b>20721</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)                    |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Operator IBM</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>N/A</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Eugene Jenifer</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Addie Davis</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Catherine Gillespie/Daughter</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2308- Good Hope Rd., SE #102 Wash., D.C. 20020</b>                         |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>4/5/99 Brentwood, Md.</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |  |  | 22. Name and Address of Facility<br><b>c/o Hackett's Funeral Chapel<br/>814- Upshur Street, N.W.</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CONGESTIVE HEART FAILURE</b>   |  |  |  |  |  |   | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)  |  |  |  |  |  |   |  |
|   | 28b. Time of Injury<br><b>M</b>  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |  |
|   | 28d. Describe how injury occurred  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
|   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>039550</b>   |  |  |  |  |  |   |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>3-28-99</b>  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George C. Hajjar, Jr. M.D. 4850 Forbes Blvd Lanham, Md 20706</b>  |  |  |  |  |  |   |  |
|   | 31. Data filed (Month, Day, Year)<br><b>APR 02 1999</b>  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |  |   |  |
|   | 33. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |  |   |  |







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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 12342

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |   |  |                                 |  |  |  |
|---|--|---|--|---|--|---------------------------------|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Helene Cleveland Bost</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 23, 1999</b>   |  |                                 |  | 3. Time of Death<br><b>1:03 pm</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Calvert County Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>   |  |                                 |  | 4c. County of Death<br><b>Calvert</b>  |  |
| 5. Social Security Number<br><b>579-30-6809</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Jan. 4, 1914</b>  |  |   |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  |                                 |  |  |  |
| Usual Residence of Decedent   |  |   |  |   |  |                                 |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Calvert</b>   |  | 10c. City, Town or Location<br><b>Lusby</b>   |  |                                 |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>846 San Mateo Trail</b>  |  |   |  | 10f. Zip Code<br><b>20657</b>   |  |                                 |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>   |  |                                 |  | 16b. Kind of Business/Industry<br><b>Retail Sales</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Cleveland Hedrick</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Virginia Hoskins</b>   |  |                                 |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Judith A. Amos - Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>846 San Mateo Trail, Lusby, Maryland 20657</b>  |  |                                 |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |  | Date<br><b>03/26/99</b>         |  | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>                                  |  |
| 21. Signature of Funeral Service Licensee<br><b>Claudette J. Dorsch</b>   |  |   |  | 22. Name and Address of Facility<br><b>Gasch's Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</b>  |  |                                 |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Respiratory FAILURE</b><br>Due to (or as a consequence of):<br><b>b. Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b> |  |   |  |   |  |                                 |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ovarian Cancer</b><br><b>Progressive Alzheimer's Disease</b>   |  |   |  |   |  |                                 |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                 |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |   |  |                                 |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                 |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |                                 |  |  |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |                                 |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |   |  | 29c. License number<br><b>033123</b>  |  |                                 |  | 29d. Date signed (Month, Day, Year)<br><b>3-26-99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jonathan Lowenthal, M.D., 120 Hospital Drive, #200, Prince Frederick, MD 20678</b>   |  |   |  |   |  |                                 |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |                                 |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

State  
Registrar

— —

March 2 1933

1933 1 0 84

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12343

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

James Wiley Bowman

2. Date of Death

Month Day Year  
March 30 1999

3. Time of Death

18:40

4a. Facility Name (If not institution, give street and number)

16 Laurel Road

4b. City, Town, or Location of Death

Perryville

4c. County of Death

Cecil

5. Social Security Number

229-24-8985

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

September 29, 1926

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Perryville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16 Laurel Road

10f. Zip Code

21903

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give US Army  
Year or Dates: 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Self-employed  
Masonry Contractor

16b. Kind of Business/Industry

Building / Masonry

17. Father's Name (First, Middle, Last)

James Aaron Bowman

18. Mother's Name (First, Middle, Maiden Surname)

Rhoda Quesinberry

19a. Informant's Name/Relationship (Type, Print)

Charles Bowman / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 Laurel Road, Perryville, MD 21903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

West Nottingham Cemetery 1999

Date

April 5

20c. Location - City or Town, State

Colora, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, MD 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. 1 yr lower lobe pneumonia

Due to (or as a consequence of):

CO2D

b. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4-6 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiovascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of causa  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D44102

29d. Date signed (Month, Day, Year)

3/31/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William Renzulli, M.D., 901 Warburton Road, Elkton, MD 21921

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12344

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruby M. Bunch

2. Date of Death  
Month Day Year  
March 31, 19993. Time of Death  
1210

4a. Facility Name (If not institution, give street and number)

Laurelwood Continuing Care Center

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

216-52-5627

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
June 10, 1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

216 Sycamore Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

in her own home

17. Father's Name (First, Middle, Last)

Charles Durham

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Barnett

19a. Informant's Name/Relationship (Type, Print)

Josephine M. Startt/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

216 Sycamore Road, Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Monticello  
Memory Gardens

Date

April 5,  
1999

20c. Location - City or Town, State

Charlottesville,  
Virginia

21. Signature of Funeral Service Licensee

Donna S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 West Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Myocardial INFARCTION  
Due to (or as a consequence of):

5 MIN.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. CORONARY ARTERY DISEASE  
Due to (or as a consequence of):

10 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Suresh Dhanjani MD

29c. License number

D45344

29d. Date signed (Month, Day, Year)

4/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH DHANJANI, MD, 20 CRAIGTOWN RD, PERRYVILLE, MD 21903

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 99 12345

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |   |   |   |                                   |  |  |
|---|--|---|---|--|--|---|---|---|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SALLY BIRCKHEAD</b>                                 |   |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>25<sup>th</sup></b> Year <b>1999</b>   |   | 3. Time of Death<br><b>1:00 AM</b>  |   |                                   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Northwest Hospital Center</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>Randallstown</b>  |   | 4c. County of Death<br><b>Baltimore</b>   |   |                                   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-22-2634</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b>  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth (Month, Day, Year)<br><b>July 22 1919 NY</b>                               |   |                                   |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>NY</b>  |   |   |  |  |   |   |   |                                   |  |  |
| Usual Residence of Decedent   |  |   |   |  |  |   |   |   |                                   |  |  |
| 10a. State<br><b>Md</b>   |  | 10b. County<br><b>Carroll</b>                         |   | 10c. City, Town or Location<br><b>Sykesville</b>   |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                   |  |  |
| 10e. Street and Number<br><b>7200 Third Avenue</b>  |  |   |   | 10f. Zip Code<br><b>21784</b>  |  | 10g. Citizen of What Country?<br><b>USA</b> |   |   |                                   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>actress/singer</b>                 |  |   | 16b. Kind of Business/Industry<br><b>entertainment</b>                                      |   |                                   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Malbone Birkhead</b>  |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Ward</b>   |   |   |   |                                   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Godfrey Birkhead (brother)</b>   |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2413 Lochness Rd Richmond, Va 23235</b>  |   |   |   |                                   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation Serv. 3-26-99</b>  |  |  | Date<br><b>3-26-99</b>                      |   | 20c. Location - City or Town, State<br><b>Hampstead, MD</b>   |                                   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Brian L. Haight</b>   |  |   |   |  | 22. Name and Address of Facility<br><b>Haight Funeral Home &amp; Chapel<br/>P.O. Box 195 Sykesville, Md 21784</b>  |   |   |   |                                   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |  |  |   |   |   |                                   | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hip Fracture</b>   |  |   |   |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |   |                                   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |   |                                   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |   |                                   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   | 29b. Signature and title of certifier<br><b>Joginder P Mehta M.D.</b>   |  |  | 29c. License number<br><b>041410</b>        |   | 29d. Date signed (Month, Day, Year)<br><b>March 25<sup>th</sup>, 1999</b>   |                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOGINDER P MEHTA, M.D. NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133</b>   |  |   |   |  |  |   |   |   |                                   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  | 32. Registrar's Signature<br><b>Beverly G. Sparks</b> |   |  |  |   |   |   |                                   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12346

|  |   |  |   |  |  |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Louise Czarn  |  |   |  | 2. Date of Death<br>Month Day Year<br>March 29, 1999   |  |  |  | 3. Time of Death<br>5:45 am  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Future Care Chesapeake  |  |   |  | 4b. City, Town, or Location of Death<br>Arnold   |  |  |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director  | 5. Social Security Number<br>223-82-8433  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>95 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 7, 1904                                  |  | 9. Birthplace (State or Foreign Country)<br>Washington, DC   |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>Maryland  |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Arnold  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|  | 10e. Street and Number<br>305 College Parkway   |  |   |  | 10f. Zip Code<br>21012   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary  |  |  |  | 16b. Kind of Business/Industry<br>U.S. Government                                    |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Edward Kline   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bessie Bowman   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br>Bernadette H. Olsen - Great Niece   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9516 Glen Ridge Drive, Laurel, Maryland 20723   |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>National Memorial Park  |  | Date<br>04/01/99   |  | 20c. Location - City or Town, State<br>Falls Church, VA                              |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Claudette J. Dorsch  |  |   |  | 22. Name and Address of Facility<br>Gasch's Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD 20781   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Atrial Fibrillation<br>Due to (or as a consequence of):<br>c. Coronary Artery Disease<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>6 mos<br>years<br>yrs  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Dementia  |  |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>Michael J. LaPenta   |  |  |  | 29c. License number<br>D21438  |  | 29d. Date signed (Month, Day, Year)<br>March 30, 1999  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Michael J. LaPenta, M.D. 600 Ridgely Avenue, #120, Annapolis, Maryland 21401  |  |   |  |  |  |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>MAR 31 1999  |  |   |  | 32. Registrar's Signature<br>B. Sparks   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-12347

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jimmy Dean Carter

2. Date of Death  
Month Day Year

MARCH 29 1999

3. Time of Death

1609

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

223-60-8674

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

July 4, 1945

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

121 Bowling Lane

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Self-employed musician

16b. Kind of Business/Industry

Entertainment  
Band

17. Father's Name (First, Middle, Last)

Eulas C. Carter

18. Mother's Name (First, Middle, Maiden Surname)

Billie Marie Tucker

19a. Informant's Name/Relationship (Type, Print)

Linda Brunner Carter / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

121 Bowling Lane, Elkton, MD 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

North East Methodist Cem.

Date

April 1

20c. Location - City or Town, State

North East, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, MD 21901

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Hepatorenal syndrome  
Due to (or as a consequence of):  
Chronic alcoholismApproximate  
Interval Between  
Onset and Deathdays  
yearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute upper GI bleed  
Multi organ system failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D45155

29d. Date signed (Month, Day, Year)

03-30-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Mulvey, M.D., 118 North Street, Elkton, MD 21921

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12348

Certificate of Death

Reg. No.

|   |   |   |  |   |  |   |  |  |
|---|---|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedant's Name (First, Middle, Last)<br><i>Mildred L. Cleaver</i>                       |   |  |   | 2. Date of Death<br>Month <i>April</i> Day <i>3</i> Year <i>1999</i> |   | 3. Time of Death<br><i>6:30 AM</i>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>6165 Telegraph Rd.</i> |   |  |   | 4b. City, Town, or Location of Death<br><i>Elkton</i>                |   | 4c. County of Death<br><i>Cecil</i>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>222-03-0182</i>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>81</i> Yrs.  | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth (Month, Day, Year)<br><i>Feb. 10, 1918</i>                                    | 9. Birthplace (State or Foreign Country)<br><i>Pennsylvania</i>  |
|   | Usual Residence of Decedent   |   |  |   |  |   |  |  |
| 10a. State<br><i>Maryland</i>   |   | 10b. County<br><i>Cecil</i>   |  | 10c. City, Town or Location<br><i>Elkton</i>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><i>6165 Telegraph Rd.</i>   |   |   |  | 10f. Zip Code<br><i>21921</i>   |  | 10g. Citizen of What Country?<br><i>USA</i> |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedant Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11</i> College (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Homemaker</i>   |  |   | 16b. Kind of Business/Industry<br><i>Own Home</i>  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Ernest Edward Jackson</i>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Florence Lillian Sewter</i>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Clyde Ben Cleaver/Husband</i>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>6165 Telegraph Rd. Elkton, MD 21921</i>   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Gracelawn Memorial Park</i>  |  | Date<br><i>4-7-99</i>                       |  | 20c. Location - City or Town, State<br><i>New Castle, Delaware</i>   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><i>R. T. Foard Funeral Home, P. A.<br/>111 S. Queen St., Rising Sun, MD 21911</i>   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><i>Immediate Cause (Final disease or condition resulting in death)</i><br><i>Congestive Heart Failure</i><br><i>Renal Failure</i><br><br><i>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</i> |   |   |  |   |  |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>COPD</i>   |   |   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |   |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                    |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |   |   |  | 28d. Describe how injury occurred   |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><i>C10002406</i>     |  | 29d. Date signed (Month, Day, Year)<br><i>4/5/99</i>   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Gary A. Beste, M.D. 313 W. Main Street Suite A Newark, DE 19711</i>  |   |   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 05 1999</i>   |   |   |  | 32. Registrar's Signature<br>   |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12349

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CANDY LEE CAFFREY

2. Date of Death

April 4 1999

3. Time of Death

1515

4a. Facility Name (If not institution, give street and number)

UNION HOSPITAL

4b. City, Town, or Location of Death

ELKTON

4c. County of Death

CECIL

Funeral  
Director

5. Social Security Number

199-52-2005

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

39

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

SEPT. 22, 1959

9. Birthplace (State or Foreign Country)

Pottstown PA.

Usual Residence of Decedent

10a. State

MD.

10b. County

CECIL

10c. City, Town or Location

NORTHEAST

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

43 EDGEWATER AVE.

10f. Zip Code

21901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES REPRESENTATIVE

16b. Kind of Business/Industry

STEEL

17. Father's Name (First, Middle, Last)

WILLIAM L. PECK

18. Mother's Name (First, Middle, Maiden Surname)

KATHRYN M. FOX PECK

19a. Informant's Name/Relationship (Type, Print)

LAWRENCE CAFFREY-HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

43 Edgewater Ave. NORTHEAST MD. 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. MICHAELS cemetery

Date

4-7-99

20c. Location - City or Town, State

UNION TWP BERKS CO. PA

21. Signature of Funeral Service Licensee

Edward H. McKeown

22. Name and Address of Facility

See FUNERAL HOME 259 E. MAIN ST. ELKTON MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Massive Bleeding IV

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cervical Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature] MD

29c. License number

D 33099

29d. Date signed (Month, Day, Year)

4/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

138 Cathedral Street, ELKTON, MD 21921

31. Date filed (Month, Day, Year)

APR 06 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

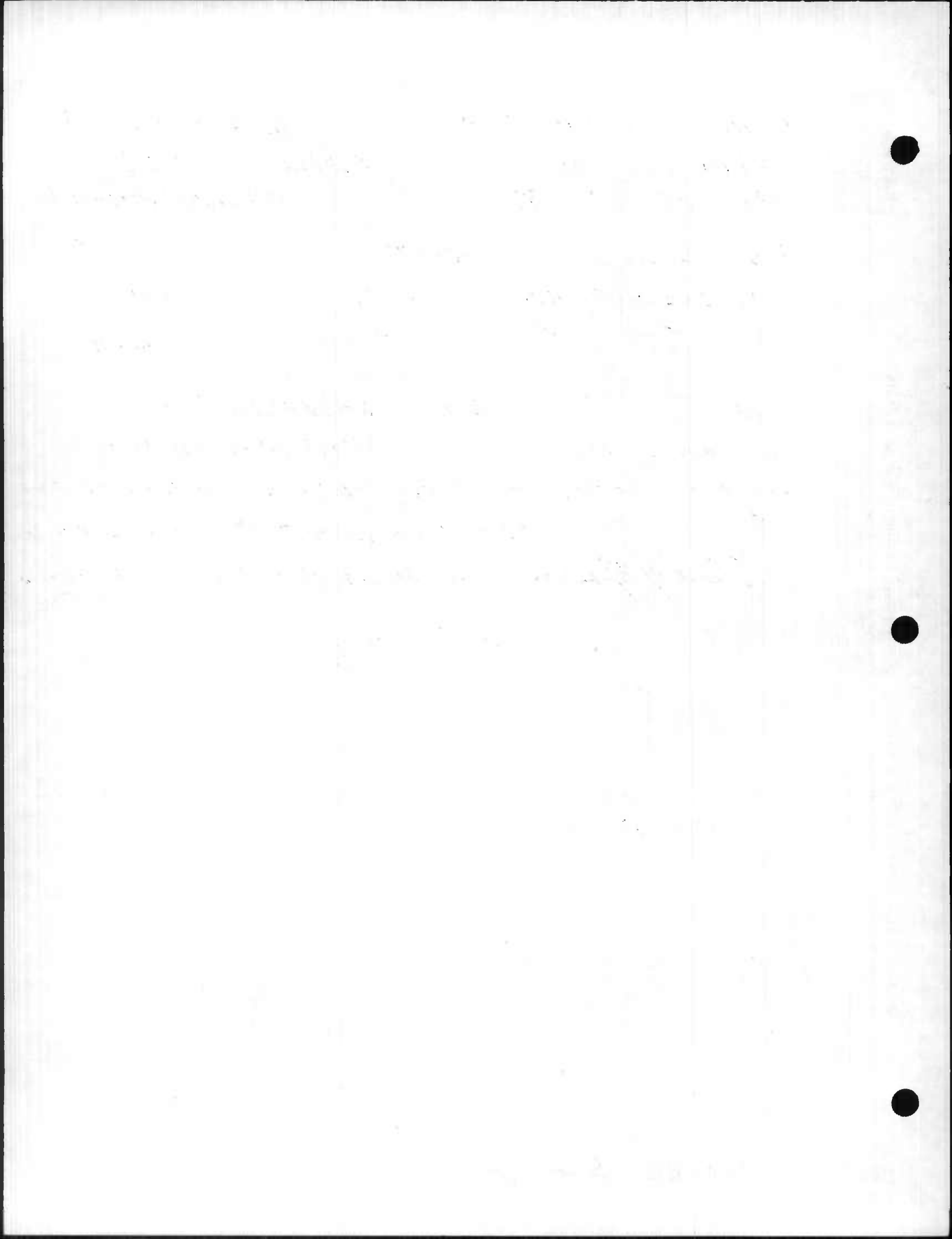
Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12350**  
**Certificate of Death**

Reg. No.

|  |   |   |  |   |   |  |  |  |
|--|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Eva Elizabeth Cincibus</b>                   |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>25</b> Year <b>1999</b> |  | 3. Time of Death<br><b>5:45am</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>7403 Second Avenue</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Sykesville</b>             |  | 4c. County of Death<br><b>Carroll</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-16-6902</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 14 1913</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |
|  | Usual Residence of Decedent   |   |  |   |   |  |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Sykesville</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>7403 Second Avenue</b>  |   |   |  | 10f. Zip Code<br><b>21784</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>secretary</b>   |   |  | 16b. Kind of Business/Industry<br><b>clerical</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lawrence Neukam</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Margaret Elizabeth Antesreiter</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Fran Greenlow (daughter)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7403 Second Ave., Sykesville, MD 21784</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bohemian National Cem.</b>   |   | Date<br><b>3-27-99</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |
| 21. Signature of Funeral Service Licensee<br><b>Paige Haight Herbert</b>   |   |   |  | 22. Name and Address of Facility<br><b>Haight Funeral Home &amp; Chapel<br/>P.O. Box 195 Sykesville, MD 21784</b>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cancer of the colon</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>10 months</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  | 29b. Signature and title of certifier<br><b>Gershon Green MD</b>  |   | 29c. License number<br><b>D1405</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/25/99</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DEPT OF SURGERY, SINAI HOSPITAL OF BALTIMORE MD 21215</b>   |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>  |   |   |  | 32. Registrar's Signature<br><b>Bruce B. Sparks</b>   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12351

|   |   |   |   |                                |  |   |  |  |
|---|---|---|---|--------------------------------|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>BERTHA ESTERLINE COX  |   |   |                                | 2. Date of Death<br>Month Day Year<br>MARCH 28 <sup>th</sup> 1999  |   | 3. Time of Death<br>4:55 AM                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>CARROLL COUNTY GENERAL HOSPITAL   |   |   |                                | 4b. City, Town, or Location of Death<br>WESTMINISTER   |   | 4c. County of Death<br>Carroll                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-74-4352  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                | 7. Age (In yrs. last birthday)<br>95 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Sep 30, 1903              |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |   | 10a. State<br>Maryland  |                                | 10b. County<br>Carroll   |   | 10c. City, Town or Location<br>Hampstead                         |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br>4211 Beckleysville Road   |                                | 10f. Zip Code<br>21074   |   | 10g. Citizen of What Country?<br>USA                             |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife                            |                                | 16b. Kind of Business/Industry<br>Own Home   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Harry Esterline  |   |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Alvira Gore   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>W. Carroll Cox, son   |   |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2233 Knox Ave, Reisterstown, MD 21136   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hereford Baptist Ch Cem   |                                | 20c. Date<br>3/31  |   | 20d. Location - City or Town, State<br>Hereford, MD              |  |
|   | 21. Signature of Funeral Service Licensee<br>Eline  |   |   |                                | 22. Name and Address of Facility<br>Eline Funeral Home<br>934 South Main St, Hampstead, MD 21074   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Acute Bronchitis<br>Due to (or as a consequence of):<br>Old age<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of): |   |   |                                |  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension<br>Carcinoma of Breast   |   |   |                                |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |                                |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |                                |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |                                |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |                                |  |   |  |  |
| 29b. Signature and title of certifier<br>MD   |   |   |   | 29c. License number<br>D 51596 |  | 29d. Date signed (Month, Day, Year)<br>MARCH 28 <sup>th</sup> 1999                          |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>K. AMBALAVANAR, CARROLL COUNTY GENERAL HOSPITAL, 200 MEMORIAL AVENUE, WESTMINISTER, MD 21157  |   |   |   |                                |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 30 1999  |   | 32. Registrar's Signature<br>B. Sparks  |   |                                |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 19a, per F.D.  
4/1/99, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12352

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>HELEN REBECCA CARMACK</b>  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 28, 1999</b>   |   | 3. Time of Death<br><b>5:48 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>GENESIS ELDERCARE</b>  |  |   | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |
| 5. Social Security Number<br><b>187-10-9252</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>4/7/1917</b>   |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |   |  |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>PA.</b>  | 10b. County<br><b>YORK</b>   | 10c. City, Town or Location<br><b>YORK</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>3020 E. PROSPECT RD.</b>   |  |   | 10f. Zip Code<br><b>17402</b>   |  | 10g. Citizen of What Country?<br><b>USA.</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>INSURANCE REPRESENTATIVE</b>  |   | 16b. Kind of Business/Industry<br><b>INSURANCE</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>MORRIS L. MARTIN</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EDITH BISH</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARSHA L. MARTIN - NIECE</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>483 S.E. 4th Ave., Melrose, FL 32666-5422</b> |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>  |   | 20c. Location - City or Town, State<br><b>4/1/99 BALTIMORE, MD.</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Thom Fletcher</i>   |  | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME</b><br><b>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CEREBROVASCULAR ACCIDENT</b>  |  |   |   |  | Approximate Interval Between Onset and Death<br><b>WKS</b>   |
| Due to (or as a consequence of):<br><b>HYPERTENSION</b>   |  |   |   |  | <b>YRS</b>   |
| Due to (or as a consequence of):  |  |   |   |  |  |
| Due to (or as a consequence of):  |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ABDOMINAL ANEURYSM</b>   |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>  |  |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Kenneth M. [Signature]</i>  |  | 29c. License number<br><b>520333</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K. ZIMMER MD 1838 GREENACRE AD PIKENUNGE MD</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12353

|   |  |  |  |  |  |  |                                |   |   |  |  |  |
|---|--|--|--|--|--|--|--------------------------------|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>John Theodore Connell, Sr.   |  |  |  | 2. Date of Death<br>Month Day Year<br>March 30 1999  |  |                                |   | 3. Time of Death<br>10:20 AM  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>3975 Baptist Rd.   |  |  |  | 4b. City, Town, or Location of Death<br>Taneytown  |  |                                |   | 4c. County of Death<br>Carroll  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>213-32-6567   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>63 Yrs.  |  | If Under 1 Year<br>Months Days |   | 8. Date of Birth (Month, Day, Year)<br>Oct. 13, 1935  |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |  |
|   | Usual Residence of Decedent  |  |  |  | 10e. State<br>MD   |  |                                |   | 10b. County<br>Carroll  |  | 10c. City, Town or Location<br>Taneytown                 |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br>3975 Baptist Rd.   |  |                                |   | 10f. Zip Code<br>21787  |  | 10g. Citizen of What Country?<br>U.S.A.                  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |                                |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8   |  |                                |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>owner/operator   |  |  |  |
|   | 16b. Kind of Business/Industry<br>rental properties  |  |  |  | 17. Father's Name (First, Middle, Last)<br>Joseph James Connell, Sr.   |  |                                |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Marie Knouff   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>M. Charlotte Connell - wife  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3975 Baptist Rd., Taneytown, MD 21787   |  |                                |   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  |
|   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Paul's Luth. Cem.  |  |  |  | 20c. Location - City or Town, State<br>4/2/99 Uniontown, MD  |  |                                |   | 21. Signature of Funeral Service Licensee<br>   |  |  |  |
|   | 22. Name and Address of Facility<br>Hartzler Funeral Home<br>310 Church St., New Windsor, MD 21776   |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>RESPIRATORY FAILURE</u><br>Due to (or as a consequence of):<br>b. <u>C.O.P.D.</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                |   | Approximate Interval Between Onset and Death<br>Hours: <u>None</u><br>Years: <u>Years</u>   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |                                |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                |   | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |                                | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br>D14317  |  |  |                                | 29d. Date signed (Month, Day, Year)<br>3/31/99  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>WILLIAM R. LINTHICUM, M.D. ONE KINGS DRIVE, TANEYTOWN, MD 21787 |  |  |  | 31. Date filed (Month, Day, Year)<br>APR 01 1999                             |  |  |                                | 32. Registrar's Signature<br>   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #18, per F.D.  
4/7/99, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12354

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |                                |  |   |
|--|--|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Betty June Concha</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>30</b> Year <b>1999</b>  |                                | 3. Time of Death<br><b>2:40 A.M.</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Fairhaven Health Care Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Sykesville</b>  |                                | 4c. County of Death<br><b>Carroll</b>  |   |
| 5. Social Security Number<br><b>501 10 2557</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>June 12, 1923</b>  | 9. Birthplace (State or Foreign Country)<br><b>N.D.</b> |
| Usual Residence of Decedent  |  |   |  |  |                                |  |   |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Sykesville</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>7200 Third Ave.</b>   |  |   |  | 10f. Zip Code<br><b>21784</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)   |  |   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |                                | 16b. Kind of Business/Industry<br><b>Public School</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Paul Miller</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><del>Bernice Melby</del> <b>Beatrice Melby</b>  |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Adela LeBrun (daughter)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11637 Long Green Pike Glen Arm, Md. 21057</b>  |                                |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Park</b>  |  | Date<br><b>4/6/99</b>  |                                | 20c. Location - City or Town, State<br><b>Beavercreek, OH</b>  |   |
| 21. Signature of Funeral Service Licensee<br><b>Brian D. Haight</b>  |  |   |  | 22. Name and Address of Facility<br><b>Sykesville, Md. 21784<br/>Haight Funeral Home P.O.Box 195</b>   |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>chronic obstructive pulmonary disease and muscular dystrophy</b>   |  |   |  |  |                                | Approximate Interval Between Onset and Death<br><b>many years</b>  |   |
| Immediate Cause (Final disease or condition resulting in death)  |  |   |  |  |                                |  |   |
| Due to (or as a consequence of):   |  |   |  |  |                                |  |   |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |  |                                |  |   |
| Due to (or as a consequence of):   |  |   |  |  |                                |  |   |
| Due to (or as a consequence of):   |  |   |  |  |                                |  |   |
| Due to (or as a consequence of):   |  |   |  |  |                                |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>depression</b><br><b>alcoholism</b>   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|  |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
|  |  | 28d. Describe how injury occurred   |  |  |                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Erin C. M. MD</b>   |  | 29c. License number<br><b>134406</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>March 30, 1999</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Richmond P. Allan, 1645 Liberty Rd., Eldersburg, MD 21784</b>   |  |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |                                |  |   |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12355

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SHAWANA MAXINE CLARK

2. Date of Death

APRIL 8 1999

3. Time of Death

11:55am

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

None

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

19

8. Date of Birth

MARCH 20 1999

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9901 MEDICAL CENTER DR.

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

0

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Infant

16b. Kind of Business/Industry

Infant

17. Father's Name (First, Middle, Last)

MICHAEL T. CLARK

18. Mother's Name (First, Middle, Maiden Surname)

ANITA ARAUJO

19a. Informant's Name/Relationship (Type, Print)

MICHAEL T. CLARK / father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20001 SWEETGUM CIR. APT. 21 GERMANTOWN MD 20874

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ENDERS/SHIRLEY F.H.

Data

4/12

20c. Location - City or Town, State

BERRYVILLE, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HILTON FUNERAL HOME

BOX 86 BARNESVILLE, MD 20838

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. pneumothorax

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. pulmonary interstitial emphysema

Due to (or as a consequence of):

c. bronchopulmonary dysplasia

Due to (or as a consequence of):

d. extreme prematurity

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intestinal perforation.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

51461

29d. Date signed (Month, Day, Year)

4/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES ROST 9901 Medical Center Dr. Rockville, MD. 20850

31. Date filed (Month, Day, Year)

APR 1 - 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



99-1708-033

LUCILE DAVIS  
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-12356

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Pearl Davis

2. Date of Death  
Month Day Year  
MARCH 22 1999

3. Time of Death

22:01

4a. Facility Name (If not institution, give street and number)

doctors hospital

4b. City, Town, or Location of Death

lanham

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

579-28-5133

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 14, 1922

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6611 Merritt Street

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Charles Harvey

18. Mother's Name (First, Middle, Maiden Surname)

Marie Barnes

19a. Informant's Name/Relationship (Type, Print)

Marlene Estes / Neice

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6611 Merritt St. Forestville, Maryland 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lincoln Memorial Park

Date

3/29/99

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

Kendra Sarge M.D.S.

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Maryland 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute, MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

MARCH 23, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

99-12357

Reg. No.

|  |   |                               |   |   |  |   |   |  |  |  |
|--|---|-------------------------------|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Ella Dull</b>                         |                               |   |   | 2. Date of Death<br>Month Day Year<br><b>March 16, 1999</b>  |   | 3. Time of Death<br><b>11:15 A.M.</b>   |  |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>2529 Hanover Pk.</b> |                               |   |   | 4b. City, Town, or Location of Death<br><b>Hampstead</b>   |   | 4c. County of Death<br><b>Carroll</b>   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-09-5410</b>   |                               | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth (Month, Day, Year)<br><b>Jul 26, 1919</b>  |  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                               |                               |   |   |  |   |   |  |  |  |
| Usual Residence of Decedent  |   |                               |   |   |  |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Carroll</b> |   | 10c. City, Town or Location<br><b>Hampstead</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 10e. Street and Number<br><b>2529 Hanover Pike</b>   |   |                               |   | 10f. Zip Code<br><b>21074</b>   |  | 10g. Citizen of What Country?<br><b>USA</b> |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)   |   |                               |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machinist</b>                 |  |   | 16b. Kind of Business/Industry<br><b>Black &amp; Decker</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Walter Jesse Rill</b>  |   |                               |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Treva Viola Stoffle</b>   |  |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ralph Dull, son</b>   |   |                               |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2104 Sterling Ct, Hampstead, MD 21074</b> |  |   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hampstead Cemetery</b>   |   | Date<br><b>3/19</b>  |   | 20c. Location - City or Town, State<br><b>Hampstead, MD</b>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                               |   | 22. Name and Address of Facility<br><b>Eline Funeral Home<br/>934 South Main St, Hampstead, MD 21074</b>                                      |  |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |   |                               |   |   |  |   |   |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                               |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
|  |   |                               |   |   |  |   | 24a. Was an autopsy performed?<br><b>Inspection</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|  |   |                               |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |                               | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
|  |   |                               | 28d. Describe how injury occurred   |   |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|  |   |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                               | 29b. Signature and title of certifier<br>   |   |  | 29c. License number<br><b>O.C.M.E.</b>      |   | 29d. Date signed (Month, Day, Year)<br><b>March 23, 1999</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201</b>  |   |                               |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |   |                               | 32. Registrar's Signature<br>   |   |  |   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at 202-535-0053.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12358

|   |  |  |                          |   |  |  |  |  |
|---|--|--|--------------------------|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>Phoenix A. Davis</b>  |  |                          |   | 2. Date of Death<br>Month Day Year<br><b>March 28, 1999</b>  |  | 3. Time of Death<br><b>8:30 A.M.</b>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Larkin Chase Nursing Facility</b>   |  |                          |   | 4b. City, Town, or Location of Death<br><b>Bowie</b>   |  | 4c. County of Death<br><b>Prince George's</b>                                  |  |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>579-09-9078</b>  |  | 6. Sex<br><b>1 M 2 F</b> |   | 7. Age (in yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>6/4/17</b>                           |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>N. Carolina</b>   |  | 10a. State<br><b>Md.</b> |   | 10b. County<br><b>P.G.</b>   |  | 10c. City, Town or Location<br><b>Capitol Hgts.</b>                            |  |
| To Be Completed by Funeral Director                     | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |  |                          |   | 10e. Street and Number<br><b>1210 Carrington Ave.</b>  |  | 10f. Zip Code<br><b>20743</b>  |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |                          |   | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><b>1 Yes 2 No</b>               |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 No</b>  |  |                          |   | 14. Race - American Indian, Black, White, etc.<br><b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>11th</b> |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>  |  |                          |   | 16b. Kind of Business/Industry<br><b>Self-Employed</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Clarence W. Davis, Sr.</b>   |  |                          |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia L. Parker</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lynette V. Bowman/Daughter</b>  |  |                          |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6100 Middleton Ln., Temple Hills, Md. 20748</b>  |  |  |  |
|   | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |  |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND NATIONAL MEMORIAL PARK</b>   |  | 20c. Location - City or Town, State<br><b>LAUREL, MARYLAND</b>                 |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Ray H. Pratt</b>   |  |                          |   | 22. Name and Address of Facility<br><b>H.S. Washington &amp; Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Respiratory failure</b><br><b>b. COPD</b><br><b>c. METASTATIC PROSTATE CANCER</b> |  |                          |   | Approximate Interval Between Onset and Death<br><b>&gt; 2 days</b><br><b>&gt; 6 months</b><br><b>&gt; one year</b>   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                          |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |  |  |  |
| Physician<br>/Medical<br>Examiner                       | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |  |                          |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |  |                          |   | 26. Place of Death (Check only one)<br><b>1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)</b>   |  |  |  |
|   | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>  |  |                          |   | 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of injury M 28c. Injury at Work? 1 Yes 2 No</b>  |  |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                          |   | 28d. Describe how Injury occurred  |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                          |   | 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> |  |  |  |
| State<br>Registrar                                      | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |                          |   | 29c. License number<br><b>D-34525</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>03-29-99</b>                         |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>S. Tanardhankas, no- 4000-Mitchellville Road # 220 BOWIE MD -20716</b>  |  |                          |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b> |  |  |                          | 32. Registrar's Signature<br><b>[Signature]</b> |  |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 12359

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM J. DeJARNETTE

2. Date of Death  
Month Day Year  
MAR. 30, 19993. Time of Death  
10:10 PM

4e. Facility Name (If not institution, give street and number)

NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-22-1674

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 20, 1906

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY CO.

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9701- VEIRS DRIVE

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates: UNKNOWN13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

ASST. COMPTROLLER

16b. Kind of Business/Industry

UNKNOWN

17. Father's Name (First, Middle, Last)

JOHN WILLIAM DeJARNETTE

18. Mother's Name (First, Middle, Maiden Surname)

RUTH JAMISON

19a. Informant's Name/Relationship (Type, Print)

REV. DR. REICHARD- EXECUTOR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9701- VEIRS DR., ROCKVILLE, MD.

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CEDAR HILL CEMETERY

Date

4/3/99

20c. Location - City or Town, State

SUITLAND, MD.

21. Signature of Funeral Service Licensee

W. H. Hyatt

22. Name and Address of Facility

HYSONG CO., INC.

1300- N STREET, NW, WASH., DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Bilateral pneumonia

Due to (or as a consequence of):

chronic renal failure

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

7 weeks

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease  
pace maker

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Charles W. Karesht

29c. License number

D21726

29d. Date signed (Month, Day, Year)

March 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CHARLES W. KARESHT- 9701 VEIRS DR. ROCKVILLE, MD

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

Signature of Registrar

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1950. 9. 11

SECTION

1950. 9. 11

1950. 9. 11

1950. 9. 11

1950. 9. 11

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12360

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH A.

2. Date of Death

Month

Day

Year

APRIL 3 1999

3. Time of Death

15:21 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

5. Social Security Number

222-10-5652

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 4 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

DE

10b. County

New Castle

10c. City, Town or Location

Wilmington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1110 Highgate Rd.

10f. Zip Code

19808

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Retail Seafood

17. Father's Name (First, Middle, Last)

Howard Outten

18. Mother's Name (First, Middle, Maiden Surname)

Enath Caulk

19a. Informant's Name/Relationship (Type, Print)

William DiVirgilio

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1110 Highgate Rd. Wilmington, DE. 19808

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

All Saints Cemetery

Date

4/8/99

20c. Location - City or Town, State

Newark, DE.

21. Signature of Funeral Service Licensee

M00510

22. Name and Address of Facility

McCrery Funeral Home

3710 Kirkwood Hwy. Wilmington DE. 19808

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

LIVER NECROSIS

Due to (or as a consequence of):

2 DAYS

b.

SHOCK

Due to (or as a consequence of):

2 DAYS

c.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

DECLAN HEGARTY MD

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

APRIL 3 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DECLAN HEGARTY MD JOHNS HOPKINS HOSPITAL BALTIMORE MD 1999

31. Date filed (Month, Day, Year)

APR 06 1999

32. Registrar's Signature

Brenda B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12361

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |   |  |  |   |  |  |   |  |  |  |
|--|---|--|---|---|--|---|--|--|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>WILLIAM THOMAS DAVIS JR.</i>   |  |   |   | 2. Date of Death<br>Month <i>APRIL</i> Day <i>05</i> Year <i>1999</i>  |   |  |  | 3. Time of Death<br><i>0520</i>   |  |  |   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>UNION HOSPITAL</i>   |  |   |   | 4b. City, Town, or Location of Death<br><i>ELKTON MD.</i>  |   |  |  | 4c. County of Death<br><i>CECIL</i>                                     |  |  |   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>214-12-4051</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><i>86</i> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><i>AUG 18, 1912 MD.</i> |  | 9. Birthplace (State or Foreign Country)                                |  |  |   |  |  |  |
|  | Usual Residence of Decedent   |  |   |   | 10a. State<br><i>MD.</i>   |   |  |  | 10b. County<br><i>CECIL</i>   |  | 10c. City, Town or Location<br><i>ELKTON</i>   |   |  |  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   | 10e. Street and Number<br><i>187 HOLLINGSWORTH MANOR</i>   |   |  |  | 10f. Zip Code<br><i>21921</i>   |  | 10g. Citizen of What Country?<br><i>U.S.A.</i> |   |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |  |  |   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>LABOR SCHULT</i>   |   |  |  | 16b. Kind of Business/Industry<br><i>MOBILE HOME</i>                    |  |  |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>WILLIAM T. DAVIS SR.</i>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>EFFIE MAY WHIRLOW</i>  |   |  |  |   |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19e. Informant's Name/Relationship (Type, Print)<br><i>RUTH ANN DAVIS-DAUGHTER</i>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>309 HOLLINGSWORTH MANOR ELKTON MD. 21921</i>   |   |  |  |   |  |  |   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>R.A. FERRIS INC</i>  |   | Date<br><i>4-8-99</i>  |   | 20c. Location - City or Town, State<br><i>W. Chester PA.</i>   |  |   |  |  |   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Edith McKinnon</i>  |  |   |   | 22. Name and Address of Facility<br><i>See FANCIAL HOME 259 E. MAIN ST. ELKTON MD.</i>   |   |  |  |   |  |  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Pneumonia</i><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |   |   | Approximate Interval Between Onset and Death<br><i>1 week</i>  |   |  |  |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Abdominal Aortic Aneurysm; Hypertension;<br/>Acute Renal Failure; Anemia; Chronic obstructive pulmonary disease.</i>  |   |  |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   | 29b. Signature and title of certifier<br><i>Monte Malone, MD</i>  |  |   |  | 29c. License number<br><i>D-44783</i>  |   |  |  | 29d. Date signed (Month, Day, Year)<br><i>APRIL 5, 1999</i>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>MONTA</i>   |   |  |   |   |  |   |  |  |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 06 1999</i>  |   |  |   | 32. Registrar's Signature<br><i>Andrew G. Sparks</i>  |  |   |  |  |   |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 12362

ITEM: #8 PER F.H. G770 4-15-99 WR.

## Certificate of Death

Reg. No.

|   |   |                               |   |   |  |  |  |   |
|---|---|-------------------------------|---|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>George Lincoln Dinterman</b>                   |                               |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>28</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>6:10 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>343 N. Colonial Ave.</b> |                               |   |   | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |  | 4c. County of Death<br><b>Carroll</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-32-4792</b>   |                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 12</b><br><b>March 12, 1930</b>                 | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
|   | Usual Residence of Decedent   |                               |   |   |  |  |  |   |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Carroll</b> |   | 10c. City, Town or Location<br><b>Westminster</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>30 South Church St</b>   |   |                               |   | 10f. Zip Code<br><b>21157</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |   |                               |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>   |  |  | 16b. Kind of Business/Industry<br><b>Carroll County Board of Education</b>                     |   |
| 17. Father's Name (First, Middle, Last)<br><b>George E. Dinterman</b>   |   |                               |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lettie Strawsburg</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mitchell Dinterman (son)</b>   |   |                               |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1130 Mahurn Rd. Westminster MD 21157</b>  |  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                               |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation Inc.</b>   |  | 20c. Location - City or Town, State<br><b>3/29/99 Hampstead, MD</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br><b>John K. [Signature]</b>   |   |                               |   | 22. Name and Address of Facility<br><b>Pitts Funeral Home + Chapel, P.A.</b><br><b>412 Washington Rd Westminster MD 21157</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Liver Cancer</b><br>Due to (or as a consequence of):<br>b. <b>Hepatitis C</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |   |                               |   |   |  |  |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                               |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |   |                               |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                               |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |                               |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   |   |                               |   | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                               |   | 29c. License number<br><b>00051924</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3-29-99</b>  |  |   |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |   |                               |   | 29a. Name and address of person who completed and sent (Item 26) (Type Name)<br><b>295 Stoner Ave Ste 307, Westminster, MD 21157</b>  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |   |                               |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12363

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARTHA LEE FRANKLIN

2. Date of Death  
Month Day Year  
MARCH 25, 1999  
3. Time of Death  
8:00 P.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF BETHESDA

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

252-46-1509

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 6, 1928

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5721 GROVESNOR LANE

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
1216a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ENVIROMENTAL ENGINEER

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

ROBERT WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE GREIR

19a. Informant's Name/Relationship (Type, Print)

CARLA SINGLETON / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

633 STILLWATER PLACE, MITCHELLVILLE, MD 20721

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BENTLEY &amp; SONS FUNERAL HOME 4-1-99 MACON, GA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME

5538 MARLBORO PIKE, FORESTVILLE, MD 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

RESPIRATORY FAILURE

SUDDEN

e. Due to (or as a consequence of):

b. Alzheimers Disease

7 Years

Due to (or as a consequence of):

c. Recurrent Bronchitis

3 Months

Due to (or as a consequence of):

d. Diabetes Mellitus

10 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D20065

29d. Date signed (Month, Day, Year)

March 30, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

EVA MORREL M.D.

MARINER HEALTH OF BETHESDA, MARYLAND

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
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/Medical  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12364

Certificate of Death

Reg. No.

|  |  |   |  |   |   |  |  |  |
|--|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Mary E. Farrington   |   |  |   | 2. Date of Death<br>Month Day Year<br>March 29 1999     |  | 3. Time of Death<br>10:59PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>6536 Buckland Court  |   |  |   | 4b. City, Town, or Location of Death<br>Fort Washington |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director  | 5. Social Security Number<br>223-02-1078   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>42 Yrs.   | If Under 1 Year<br>Months Days                          | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth (Month, Day, Year)<br>Aug. 8, 1956  | 9. Birthplace (State or Foreign Country)<br>Virginia                                 |
|  | Usual Residence of Decedent  |   |  |   |   |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Ft. Washington   |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br>6536 Buckland Court  |  |   |  | 10f. Zip Code<br>20744  |   | 10g. Citizen of What Country?<br>United States |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>12th  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales Representative   |   |  | 16b. Kind of Business/Industry<br>Private  |  |
| 17. Father's Name (First, Middle, Last)<br>Ben Albert Bracey   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ethel Northington  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>John Farrington - Husband  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6536 Buckland Ct., Ft. Washington, MD 20744  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Westview Cemetery   |   | Date<br>4/3/99                                 |  | 20c. Location - City or Town, State<br>South Hill, VA                                |
| 21. Signature of Funeral Service Licensee<br>John T. Stewart, III  |  |   |  | 22. Name and Address of Facility<br>Stewart Funeral Home<br>4001 Benning Rd., N.E. Wash., D.C. 20019  |   |  |  |  |
| Physician<br>/Medical<br>Examiner  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Metastatic Lung Cancer<br>Due to (or as a consequence of):<br>with Liver and Bone metastasis 2 years<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |   |  | Approximate Interval Between Onset and Death   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes mellitus<br>Hypertension  |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br>Sajeer Anand M.D.  |   | 29c. License number<br>D-33482                 |  | 29d. Date signed (Month, Day, Year)<br>March 31, 1998                                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Sajeer Anand, M.D. 7343-A Hanover parkway, Greenbelt, Md. 20770  |  |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999   |  |   |  | 32. Registrar's Signature<br>S. Anand   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



99 12365

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNA BOWMAN FAIRBANK</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 31, 1999</b>   |  | 3. TIME OF DEATH<br><b>7:00 a.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>189-18-7112 A</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept. 9, 1911</b>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Penna.</b>  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shorw Nursing and Rehabilitation</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Denton</b>  |  | 9c. COUNTY OF DEATH<br><b>Caroline</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Denton</b>  |  | 10b. COUNTY<br><b>Caroline</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Denton</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>Colonial Dr. Homestead Manor</b>  |  |  |  | 10f. ZIP CODE<br><b>21629</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Bowman</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Cora Young</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marion Voeste Daughter</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>28320 Canvasback Lane Easton, Maryland 21601</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Capitol Crematory 3-31-99</b>  |  | 20c. LOCATION — City or Town, State<br><b>Dover, Delaware</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Hansen E. Leonard</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Harrison E. Leonard Funeral Home 21663<br/>312 S. Talbot St. St. Michaels, Maryland</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial infarction</b>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| b. <b>Coronary artery disease</b>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c. <b>Atrial fibrillation</b>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d. <b>Dementia</b>   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John MO</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>00051132</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-31-99</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jorge Abrego M.D. Daffin Lane Denton, Maryland 21629</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 01 1999</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Benjamin B. Sparks</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 1 of 1000  
Page 1 of 1000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12366

|                                     |  |  |  |  |   |                                |  |   |
|-------------------------------------|--|--|--|--|---|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EDWIN NEFF FAYE</b>   |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>29</b> Year <b>1999</b>   |                                | 3. Time of Death<br><b>1135 A.M.</b>   |   |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Dorchester General Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Cambridge</b>  |                                | 4c. County of Death<br><b>Dorchester</b>   |   |
| Funeral<br>Director                 | 5. Social Security Number<br><b>185-20-5798</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>April 6, 1928</b>  | 9. Birthplace (State or Foreign Country)<br><b>Penna.</b> |
|                                     | Usual Residence of Decedent  |  |  |  | 10c. City, Town or Location<br><b>Tilghman</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| To Be Completed by Funeral Director | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Talbot</b>   |  | 10e. Street and Number<br><b>21290 Landing Lane</b>   |                                | 10f. Zip Code<br><b>21671</b>  |   |
|                                     | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>                       |                                | 16b. Kind of Business/Industry<br><b>AT&amp;T</b>  |   |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Edwin Faye</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura Yaeger</b>  |                                |  |   |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marijune Faye Wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 388 Tilghman, Maryland 21671</b>     |                                |  |   |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Capitol Crematory</b>   |  | Date<br><b>March 31, 1999</b>   |                                | 20c. Location - City or Town, State<br><b>Dover, Delaware</b>  |   |
|                                     | 21. Signature of Funeral Service Licensee<br><i>Harrison E. Leonard</i>  |  |  |  | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>                    |                                |  |   |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |                                |  |   |
|                                     | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>YEARS</b>   |  |  |  |   |                                |  |   |
|                                     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>c.<br>d.<br>e.<br>f.<br>g.<br>h.<br>i.<br>j.<br>k.<br>l.<br>m.<br>n.<br>o.<br>p.<br>q.<br>r.<br>s.<br>t.<br>u.<br>v.<br>w.<br>x.<br>y.<br>z.<br>aa.<br>ab.<br>ac.<br>ad.<br>ae.<br>af.<br>ag.<br>ah.<br>ai.<br>aj.<br>ak.<br>al.<br>am.<br>an.<br>ao.<br>ap.<br>aq.<br>ar.<br>as.<br>at.<br>au.<br>av.<br>aw.<br>ax.<br>ay.<br>az.<br>ba.<br>bb.<br>bc.<br>bd.<br>be.<br>bf.<br>bg.<br>bh.<br>bi.<br>bj.<br>bk.<br>bl.<br>bm.<br>bn.<br>bo.<br>bp.<br>bq.<br>br.<br>bs.<br>bt.<br>bu.<br>bv.<br>bw.<br>bx.<br>by.<br>bz.<br>ca.<br>cb.<br>cc.<br>cd.<br>ce.<br>cf.<br>cg.<br>ch.<br>ci.<br>cj.<br>ck.<br>cl.<br>cm.<br>cn.<br>co.<br>cp.<br>cq.<br>cr.<br>cs.<br>ct.<br>cu.<br>cv.<br>cw.<br>cx.<br>cy.<br>cz.<br>da.<br>db.<br>dc.<br>dd.<br>de.<br>df.<br>dg.<br>dh.<br>di.<br>dj.<br>dk.<br>dl.<br>dm.<br>dn.<br>do.<br>dp.<br>dq.<br>dr.<br>ds.<br>dt.<br>du.<br>dv.<br>dw.<br>dx.<br>dy.<br>dz.<br>ea.<br>eb.<br>ec.<br>ed.<br>ee.<br>ef.<br>eg.<br>eh.<br>ei.<br>ej.<br>ek.<br>el.<br>em.<br>en.<br>eo.<br>ep.<br>eq.<br>er.<br>es.<br>et.<br>eu.<br>ev.<br>ew.<br>ex.<br>ey.<br>ez.<br>fa.<br>fb.<br>fc.<br>fd.<br>fe.<br>ff.<br>fg.<br>fh.<br>fi.<br>fj.<br>fk.<br>fl.<br>fm.<br>fn.<br>fo.<br>fp.<br>fq.<br>fr.<br>fs.<br>ft.<br>fu.<br>fv.<br>fw.<br>fx.<br>fy.<br>fz.<br>ga.<br>gb.<br>gc.<br>gd.<br>ge.<br>gf.<br>gg.<br>gh.<br>gi.<br>gj.<br>gk.<br>gl.<br>gm.<br>gn.<br>go.<br>gp.<br>gq.<br>gr.<br>gs.<br>gt.<br>gu.<br>gv.<br>gw.<br>gx.<br>gy.<br>gz.<br>ha.<br>hb.<br>hc.<br>hd.<br>he.<br>hf.<br>hg.<br>hh.<br>hi.<br>hj.<br>hk.<br>hl.<br>hm.<br>hn.<br>ho.<br>hp.<br>hq.<br>hr.<br>hs.<br>ht.<br>hu.<br>hv.<br>hw.<br>hx.<br>hy.<br>hz.<br>ia.<br>ib.<br>ic.<br>id.<br>ie.<br>if.<br>ig.<br>ih.<br>ii.<br>ij.<br>ik.<br>il.<br>im.<br>in.<br>io.<br>ip.<br>iq.<br>ir.<br>is.<br>it.<br>iu.<br>iv.<br>iw.<br>ix.<br>iy.<br>iz.<br>ja.<br>jb.<br>jc.<br>jd.<br>je.<br>jf.<br>jg.<br>jh.<br>ji.<br>jj.<br>jk.<br>jl.<br>jm.<br>jn.<br>jo.<br>jp.<br>jq.<br>jr.<br>js.<br>jt.<br>ju.<br>jv.<br>jw.<br>jx.<br>jy.<br>jz.<br>ka.<br>kb.<br>kc.<br>kd.<br>ke.<br>kf.<br>kg.<br>kh.<br>ki.<br>kj.<br>kl.<br>km.<br>kn.<br>ko.<br>kp.<br>kq.<br>kr.<br>ks.<br>kt.<br>ku.<br>kv.<br>kw.<br>kx.<br>ky.<br>kz.<br>la.<br>lb.<br>lc.<br>ld.<br>le.<br>lf.<br>lg.<br>lh.<br>li.<br>lj.<br>lk.<br>ll.<br>lm.<br>ln.<br>lo.<br>lp.<br>lq.<br>lr.<br>ls.<br>lt.<br>lu.<br>lv.<br>lw.<br>lx.<br>ly.<br>lz.<br>ma.<br>mb.<br>mc.<br>md.<br>me.<br>mf.<br>mg.<br>mh.<br>mi.<br>mj.<br>mk.<br>ml.<br>mm.<br>mn.<br>mo.<br>mp.<br>mq.<br>mr.<br>ms.<br>mt.<br>mu.<br>mv.<br>mw.<br>mx.<br>my.<br>mz.<br>na.<br>nb.<br>nc.<br>nd.<br>ne.<br>nf.<br>ng.<br>nh.<br>ni.<br>nj.<br>nk.<br>nl.<br>nm.<br>nn.<br>no.<br>np.<br>nq.<br>nr.<br>ns.<br>nt.<br>nu.<br>nv.<br>nw.<br>nx.<br>ny.<br>nz.<br>oa.<br>ob.<br>oc.<br>od.<br>oe.<br>of.<br>og.<br>oh.<br>oi.<br>oj.<br>ok.<br>ol.<br>om.<br>on.<br>oo.<br>op.<br>oq.<br>or.<br>os.<br>ot.<br>ou.<br>ov.<br>ow.<br>ox.<br>oy.<br>oz.<br>pa.<br>pb.<br>pc.<br>pd.<br>pe.<br>pf.<br>pg.<br>ph.<br>pi.<br>pj.<br>pk.<br>pl.<br>pm.<br>pn.<br>po.<br>pp.<br>pq.<br>pr.<br>ps.<br>pt.<br>pu.<br>pv.<br>pw.<br>px.<br>py.<br>pz.<br>qa.<br>qb.<br>qc.<br>qd.<br>qe.<br>qf.<br>qg.<br>qh.<br>qi.<br>qj.<br>qk.<br>ql.<br>qm.<br>qn.<br>qo.<br>qp.<br>qq.<br>qr.<br>qs.<br>qt.<br>qu.<br>qv.<br>qw.<br>qx.<br>qy.<br>qz.<br>ra.<br>rb.<br>rc.<br>rd.<br>re.<br>rf.<br>rg.<br>rh.<br>ri.<br>rj.<br>rk.<br>rl.<br>rm.<br>rn.<br>ro.<br>rp.<br>rq.<br>rr.<br>rs.<br>rt.<br>ru.<br>rv.<br>rw.<br>rx.<br>ry.<br>rz.<br>sa.<br>sb.<br>sc.<br>sd.<br>se.<br>sf.<br>sg.<br>sh.<br>si.<br>sj.<br>sk.<br>sl.<br>sm.<br>sn.<br>so.<br>sp.<br>sq.<br>sr.<br>ss.<br>st.<br>su.<br>sv.<br>sw.<br>sx.<br>sy.<br>sz.<br>ta.<br>tb.<br>tc.<br>td.<br>te.<br>tf.<br>tg.<br>th.<br>ti.<br>tj.<br>tk.<br>tl.<br>tm.<br>tn.<br>to.<br>tp.<br>tq.<br>tr.<br>ts.<br>tu.<br>tv.<br>tw.<br>tx.<br>ty.<br>tz.<br>ua.<br>ub.<br>uc.<br>ud.<br>ue.<br>uf.<br>ug.<br>uh.<br>ui.<br>uj.<br>uk.<br>ul.<br>um.<br>un.<br>uo.<br>up.<br>uq.<br>ur.<br>us.<br>ut.<br>uu.<br>uv.<br>uw.<br>ux.<br>uy.<br>uz.<br>va.<br>vb.<br>vc.<br>vd.<br>ve.<br>vf.<br>vg.<br>vh.<br>vi.<br>vj.<br>vk.<br>vl.<br>vm.<br>vn.<br>vo.<br>vp.<br>vq.<br>vr.<br>vs.<br>vt.<br>vu.<br>vv.<br>vw.<br>vx.<br>vy.<br>vz.<br>wa.<br>wb.<br>wc.<br>wd.<br>we.<br>wf.<br>wg.<br>wh.<br>wi.<br>wj.<br>wk.<br>wl.<br>wm.<br>wn.<br>wo.<br>wp.<br>wq.<br>wr.<br>ws.<br>wt.<br>wu.<br>wv.<br>ww.<br>wx.<br>wy.<br>wz.<br>xa.<br>xb.<br>xc.<br>xd.<br>xe.<br>xf.<br>xg.<br>xh.<br>xi.<br>xj.<br>xk.<br>xl.<br>xm.<br>xn.<br>xo.<br>xp.<br>xq.<br>xr.<br>xs.<br>xt.<br>xu.<br>xv.<br>xw.<br>xx.<br>xy.<br>xz.<br>ya.<br>yb.<br>yc.<br>yd.<br>ye.<br>yf.<br>yg.<br>yh.<br>yi.<br>yj.<br>yk.<br>yl.<br>ym.<br>yn.<br>yo.<br>yp.<br>yq.<br>yr.<br>ys.<br>yt.<br>yu.<br>yv.<br>yw.<br>yx.<br>yy.<br>yz.<br>za.<br>zb.<br>zc.<br>zd.<br>ze.<br>zf.<br>zg.<br>zh.<br>zi.<br>zj.<br>zk.<br>zl.<br>zm.<br>zn.<br>zo.<br>zp.<br>zq.<br>zr.<br>zs.<br>zt.<br>zu.<br>zv.<br>zw.<br>zx.<br>zy.<br>zz. |  |  |  |   |                                |  |   |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12367

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marion Sylvester

Fisher

2. Date of Death

Month Day Year  
MARCH 25 1999

3. Time of Death

3:13 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

220-28-0719

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 12, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

420 Colonial Drive

10f. Zip Code

21629

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1/25/43-4/7/4313. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Waterman

16b. Kind of Business/Industry

Seafood

17. Father's Name (First, Middle, Last)

John Elbert Fisher

18. Mother's Name (First, Middle, Maiden Surname)

Arrie Bouldin

19a. Informant's Name/Relationship (Type, Print)

Diana Farmer (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3817 Swann Rd. #101, Suitland, Maryland 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Md. Veterans Cemetery

Date

3/30/99

20c. Location - City or Town, State

Beulah, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home  
P.O. Box 1687, Easton, Maryland 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Anoxic Encephalopathy

1 Day

Due to (or as a consequence of):

b. Ventricular Tachycardia

1 Day

Due to (or as a consequence of):

c. Atherosclerotic Cardiovascular Disease

Years

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Right Femur Fracture

Congestive Heart Failure

Gram Negative Rod Bacteremia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accidental 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)  
3/20/9928b. Time of  
Injury

App. 4A M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Slipped going to bath-  
room28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

Nursing Home

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

420 Colonial Dr. Denton MD

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 42005

29d. Date signed (Month, Day, Year)

March 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Lees MD 219 S. Washington St. Easton, MD 21601

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

B. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

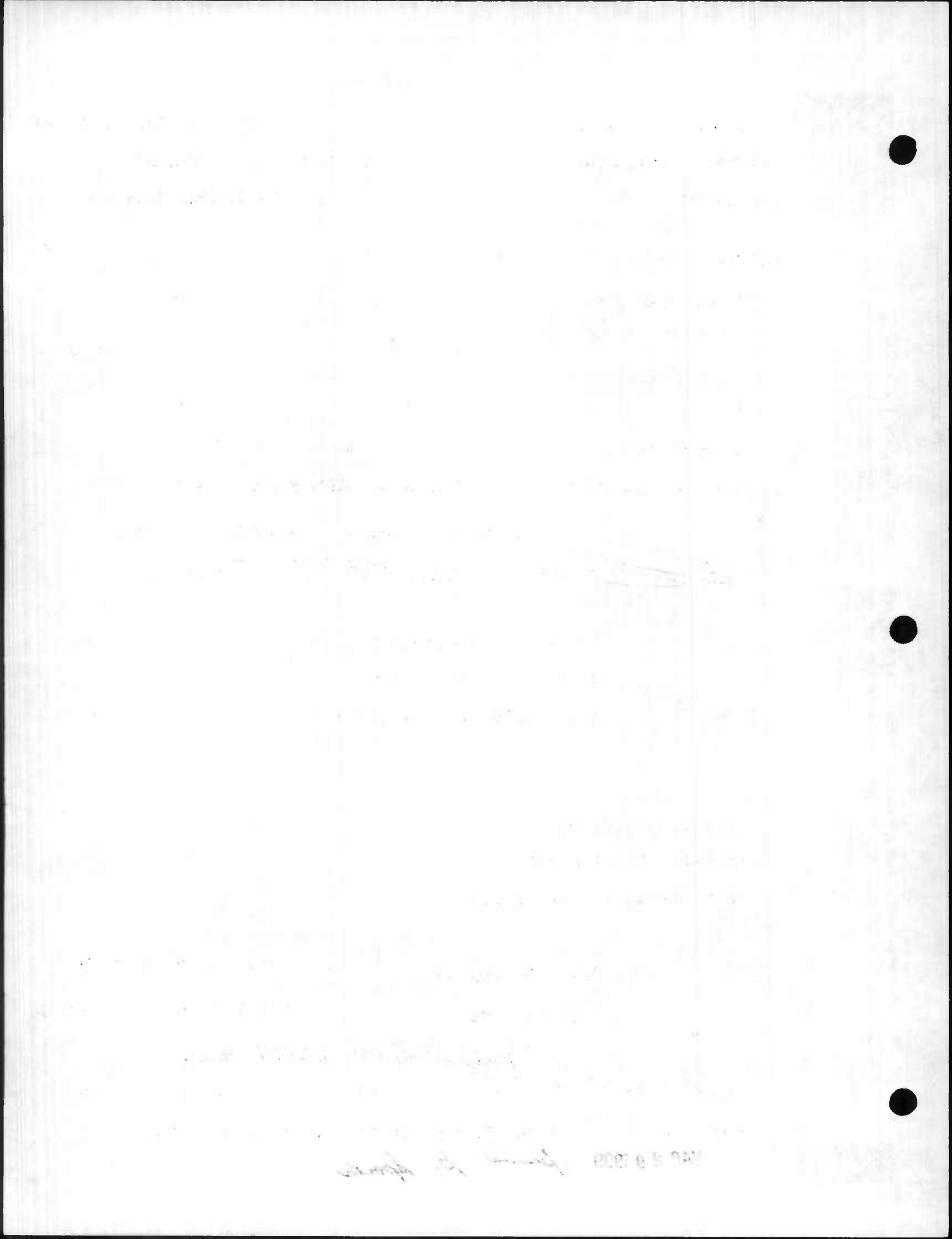
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12368

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY E. FAULKNER

2. Date of Death

Mar. 26,

Day

Year

1999

3. Time of Death

12:04 P.M.

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

213-18-4764

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 9, 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10351 OLD CORDOVA ROAD

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)  
-0-

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

BEN MELVIN

18. Mother's Name (First, Middle, Maiden Surname)

EDITH PLUMMER

19a. Informant's Name/Relationship (Type, Print)

MILTON FAULKNER / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10351 OLD CORDOVA ROAD, EASTON, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GREENMOUNT CEMETERY

Date

3-30-99

20c. Location - City or Town, State

HILLSBORO, MD

21. Signature of Funeral Service Licensee

JOHN B. MERCER

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.  
200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Approximate Interval Between Onset and Death

15 mins

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis M. DeShields

29c. License number

06053110

29d. Date signed (Month, Day, Year)

3/26/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DENNIS DESHIELDS, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Faulkner Dorothy

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
barn, Cecil Co.  
Amended Items 5, 8, 4/7/99 Certificate of Death

Reg. No.

99 12369

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline M. Freese

2. Date of Death

March 30 1999

3. Time of Death

1:44pm

4a. Facility Name (If not institution, give street and number)

Calvert Manor Healthcare Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

200-50-0254

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 31, 1909

9. Birthplace (State or Foreign Country)

Penn.

Usual Residence of Decedent

10a. State

Pa.

10b. County

Chester

10c. City, Town or Location

Oxford

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

321 Franklin st.

10f. Zip Code

19363

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
unknown

College (1-4 or 5+)  
unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William T. McGarvey

18. Mother's Name (First, Middle, Maiden Surname)

Margaret L. Davis

19a. Informant's Name/Relationship (Type, Print)

Paul Freese/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

130 Nottingham, Pa. 19362

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oxford Cemetery

Date

4/2/99

20c. Location - City or Town, State

Oxford, Pa.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Gee Funeral Home  
259 E. main St. ELKTON, MD. 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *PANCREATIC CANCER - METASTASIS*

Approximate Interval Between Onset and Death

*1 yr.*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

*DO4482*

29d. Date signed (Month, Day, Year)

*03/30/99*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*MA/COM D. Phillips, M.D., MASONIC Building, DARTINGTON, MD. 21934*

31. Date filed (Month, Day, Year)

*MAR 31 1999*

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12370

|  |   |  |  |   |   |  |   |  |   |  |
|--|---|--|--|---|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Viola M. Geist  |  |  |   | 2. Date of Death<br>Month: 03 Day: 17 Year: 1999  |  |   |  | 3. Time of Death<br>10:00 a.m.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>3906 Main Street  |  |  |   | 4b. City, Town, or Location of Death<br>Trappe  |  |   |  | 4c. County of Death<br>Talbot   |  |
| Funeral<br>Director  | 5. Social Security Number<br>172-22-2129  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>93 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>10-20-1905 |  | 9. Birthplace (State or Foreign Country)<br>Long Island, NY   |  |
|  | Usual Residence of Decedent   |  |  |   | 10a. State<br>Florida   |  | 10b. County<br>Pinellas                           |  | 10c. City, Town or Location<br>Largo  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   | 10e. Street and Number<br>2274 13th Avenue, S.W.  |  |   |  | 10f. Zip Code<br>33770  |  |
|  | 10g. Citizen of What Country?<br>United States  |  |  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12 College (1-4 or 5+)  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary  |  |  |   | 16b. Kind of Business/Industry<br>Insurance   |  |   |  | 17. Father's Name (First, Middle, Last)<br>Frederick Wittmeyer  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Bardsley  |  |  |   | 19a. Informant's Name/Relationship (Type, Print)<br>Doris Siddell / Daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2274 13th Avenue, S.W., Largo, FL 33770  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hillside Cemetery   |  |   |  | 20c. Location - City or Town, State<br>3/22/99 Roslyn, PA   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> M00510  |  |  |   | 22. Name and Address of Facility<br>Beeson Memorial Services<br>2053 Pulaski Hwy., Newark, DE 19702   |  |   |  | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Pneumonia</i><br><br>Due to (or as a consequence of):<br><i>Dementia</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>Breast Cancer</i><br><i>Atrial Fibrillation</i> |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |
|  | 28a. Date of Injury (Month, Day, Year)  |  |  |   | 28b. Time of Injury<br>M  |  |   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 28d. Describe how injury occurred  |   |  |  | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  | 29b. Signature and title of certifier<br><i>Eugene Newmeyer</i> Physician   |   |  |   | 29c. License number<br>H51793  |   |  |
| 29d. Date signed (Month, Day, Year)<br>3/17/99   |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Eugene Newmeyer DO 503 Burn St Cambridge MD 21613 |   |  |   | 31. Date filed (Month, Day, Year)<br>APR 01 1999                             |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  | 33. State Registrar<br>APR 01 1999  |   |  |   | 34. State Registrar  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

99 12371

## Certificate of Death

Reg. No.

|  |  |                                |   |  |  |   |  |  |   |  |
|--|--|--------------------------------|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Bessie May Govier                                      |                                |   |  |  |   | 2. Date of Death<br>Month Day Year<br>March 29, 1999                                 |  | 3. Time of Death<br>11:45 A.M.                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Futurecare/Pineview Nursing Home |                                |   |  |  |   | 4b. City, Town, or Location of Death<br>Clinton                                      |  | 4c. County of Death<br>Prince George's              |  |
| Funeral<br>Director  | 5. Social Security Number<br>578-84-9924   |                                | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>91 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>June 17, 1907                                 |  | 9. Birthplace (State or Foreign Country)<br>England |  |
|  | Usual Residence of Decedent  |                                |   |  |  |   |  |  |   |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Prince George's |   | 10c. City, Town or Location<br>Upper Marlboro  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br>10404 Grandhaven Avenue  |  |                                |   | 10f. Zip Code<br>20772   |  | 10g. Citizen of What Country?<br>Great Britain  |  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>Unknown  |  |                                |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |  | 16b. Kind of Business/Industry<br>Own Home  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Unknown   |  |                                |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Unknown  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Victor Govier/Son  |  |                                |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10404 Grandhaven Ave. Upper Marlboro, MD 20772   |  |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory  |  | Date<br>3/30/99  |   | 20c. Location - City or Town, State<br>Alexandria, VA                                |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>George P. Kalas</i>  |  |                                |   |  |  | 22. Name and Address of Facility<br>George P. Kalas Funeral Home, P.A.<br>6160 Oxon Hill Rd. Oxon Hill, MD 20745  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Pneumonia</i><br>Due to (or as a consequence of):<br>b. <i>CORONARY ARTERY DISEASE</i><br>Due to (or as a consequence of):<br>c. <i>s/p. cerebro vascular Accident</i><br>Due to (or as a consequence of):<br>d. <i>Hypertension</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                |   |  |  |   |  |  |   |  |
| Approximate Interval Between Onset and Death<br>2 weeks<br>10+ years<br>10+ years  |  |                                |   |  |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>osteoporosis</i><br><i>chronic Atrial Fibrillation, intermittent</i>  |  |                                |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                                |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |                                | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |                                |   |  |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Alain G. Champaloux</i>  |  |                                |   |  |  | 29c. License number<br>D42049   |  | 29d. Date signed (Month, Day, Year)<br>March 30, 1999  |   |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>Alain G. Champaloux, M.D. 14314 Old Marlboro Pike, Upper Marlboro, MD  |  |                                |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 31 1999   |  |                                |   |  |  | 32. Registrar's Signature<br><i>Anna S. Smith</i>   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

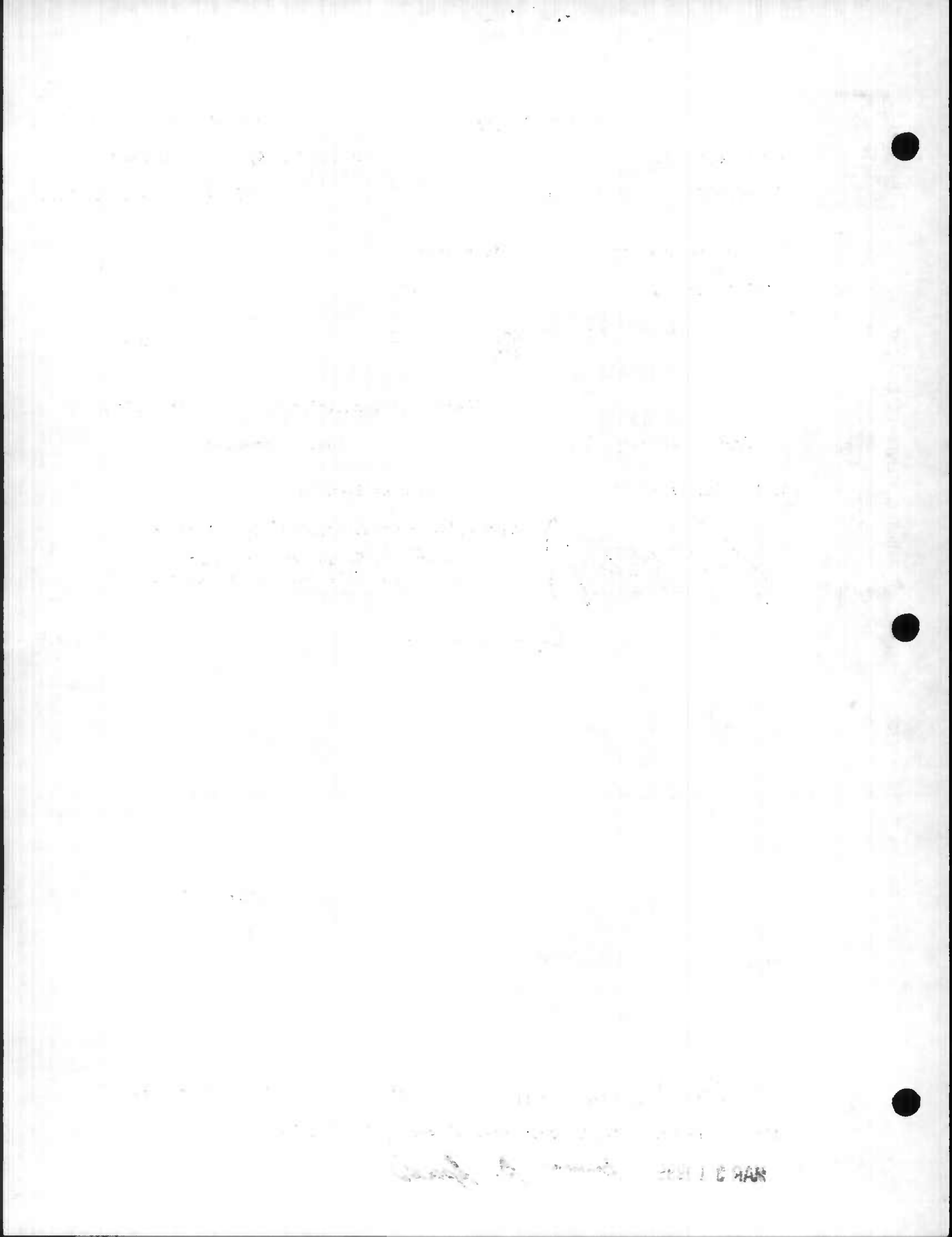
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2001 2 28 AM

99 12372

DHHM 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12373

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edna Kay Henshaw

2. Date of Death

March 29 1999 2:35 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

578-28-7909

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 4, 1900

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4302 Oglethorpe Street

10f. Zip Code

20781

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

Gordon Hugh Kay

18. Mother's Name (First, Middle, Maiden Surname)

Grace Lee Drake

19a. Informant's Name/Relationship (Type, Print)

Linda Jacobs - Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8705 Ashcroft Drive, Laurel, Maryland 20708

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Washington National Cemetery

Date

04/01/99

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

W.B. Greisen

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)e. SEPTIC  
Due to (or as a consequence of):

3 days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. CONGESTIVE HEART FAILURE  
Due to (or as a consequence of):

2 months

c. ARTERIO SCLEROTIC VASCULAR DISEASE  
Due to (or as a consequence of):

15 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

W.B. Greisen

29c. License number

015820

29d. Date signed (Month, Day, Year)

3/30/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

HONG LEE MD 3414 HANCOCK ST HYATTSVILLE MD 20782

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

A. Andre

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-12374

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARK HATCHER

2. Date of Death

Month Day Year  
March 28 1999

3. Time of Death

10:59 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

214-68-9963

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 19, 1956

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Largo

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

712 Pritchard Lane

10f. Zip Code

20774

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)

Salesman

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Theodore R. Hatcher, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Jones

19a. Informant's Name/Relationship (Type, Print)

Elizabeth K. Hatcher/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

712 Pritchard Lane, Largo, Maryland 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

04/02 1999

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perente

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME  
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Possible Acute myocardial infarction  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arrythmia  
Due to (or as a consequence of):c. Respiratory Failure  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN, Cardiomyopathy  
Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Meera Kanhouwa

29c. License number

DS2222

29d. Date signed (Month, Day, Year)

March 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

meera Kanhouwa MD

PGHC  
3001 Hospital Drive, Cheverly MD 20785

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

B. Spade

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

0000

1100

1200

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1500

1600

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11800

11900

12000

12100

12200

12300

12400

12500

12600

12700

12800

12900

13000

13100

13200

13300

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12375

|  |  |  |   |  |   |  |   |  |
|--|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Helen L. Hahn  |  |   |  | 2. Date of Death<br>Month Day Year<br>March 31, 1999  |  | 3. Time of Death<br>4:50PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Collington Episcopal Life Care |  |   |  | 4b. City, Town, or Location of Death<br>Mitchellville |  | 4c. County of Death<br>Prince George's  |  |
| Funeral<br>Director  | 5. Social Security Number<br>229-44-8717   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>90                  |  | 8. Date of Birth (Month, Day, Year)<br>April 20, 1908   |  |
|  | 9. Birthplace (State or Foreign Country)<br>Nebraska   |  | 10a. State<br>Maryland  |  | 10b. County<br>Prince George's                        |  | 10c. City, Town or Location<br>Mitchellville  |  |
| Usual Residence of Decedent  |  |  |   |  |   |  |   |  |
| 10a. State<br>Maryland   |  |  | 10b. County<br>Prince George's  |  |   | 10c. City, Town or Location<br>Mitchellville   |   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  | 10e. Street and Number<br>10450 Lottsford Road #1206  |  |   | 10f. Zip Code<br>20721   |   |  |
| 10g. Citizen of What Country?<br>U.S.A.  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Civil Service Examiner  |  |  | 16b. Kind of Business/Industry<br>Federal Government  |  |   | 17. Father's Name (First, Middle, Last)<br>Charles V. Lind   |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br>Daisy Burgstrom   |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Bruce N. Hahn/Son   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6776 Little Falls Rd. Arlington, VA 22213   |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory  |  |   | 20c. Date<br>4/1/99  |   |  |
| 20d. Location - City or Town, State<br>Alexandria, VA.   |  |  | 21. Signature of Funeral Service Licensee<br>George P. Kalas  |  |   | 22. Name and Address of Facility<br>George P. Kalas Funeral Home, P.A.<br>6160 Oxon Hill Rd. Oxon Hill, MD. 20745  |   |  |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |  |   |  |   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>Chronic Obstructive Pulmonary Disease   |  |  |   |  |   |  |   |  |
| Due to (or as a consequence of):   |  |  |   |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |   |  |   |  |   |  |
| Due to (or as a consequence of):   |  |  |   |  |   |  |   |  |
| Due to (or as a consequence of):   |  |  |   |  |   |  |   |  |
| Due to (or as a consequence of):   |  |  |   |  |   |  |   |  |
| Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.<br>Alzheimer's disease  |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                              |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 28d. Describe how injury occurred  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br>William J. / no   |  |  | 29c. License number<br>325079   |  |   | 29d. Date signed (Month, Day, Year)<br>April 1, 1999   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Don H. Yablonski, no 7404 Executive Place, Peabody, no 20706   |  |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999   |  |  | 32. Registrar's Signature<br>Barbara A. Jones   |  |   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

2007-09-25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12376

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Albert Harris

2. Date of Death

Month Day Year  
March 31 1999

3. Time of Death

10:58 a.m.

4a. Facility Name (If not institution, give street and number)

Calvert Manor Healthcare Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

216-14-3069

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 4, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Perryville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1212 Aiken Avenue Extended

10f. Zip Code

21903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1940-42

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
Twelve Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Laundry Service  
V.A. Medical Center  
Perry Point, Maryland

17. Father's Name (First, Middle, Last)

Luther Shank

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jeanette Harris

19a. Informant's Name/Relationship (Type, Print)

Francis E. Dixon (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 Barnes Corner Road, Coloma, Maryland 21917

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Principio Cemetery

Date

4/3/99

20c. Location - City or Town, State

Perryville, Maryland

21. Signature of Funeral Service Licensee

Thomas M. Patterson, Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home  
Perryville, Maryland 21903-0188

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration

Renal failure due to dehydration

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hislop Kim

29c. License number

DE6412

29d. Date signed (Month, Day, Year)

4/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hislop Kim 319 S. Union St. Perryville, MD 21917

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

13  
IVA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12377**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Burrell Leonard Jones, Jr.

2. Date of Death

Month Day Year  
MARCH 28 1999

3. Time of Death

8:37 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

233-40-5697

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 9, 1928

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1882 Iverson St.

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk/ U.S. Postal Worker

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Burrell L. Jones, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED HICKS

19a. Informant's Name/Relationship (Type, Print) Daughter  
Kimberly Jones-Randall/

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2824 Crestwick Pl. Forestville, Maryland 20747

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National Cem.

Date

4/9/99

20c. Location - City or Town, State

Arlington, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. SEVERE DIFFUSE CEREBRAL DYSFUNCTION

11 DAYS

Due to (or as a consequence of):

b. MULTIPLE BRAIN MASSES-PRESUMED METASTATIC CANCER

1 MONTH

Due to (or as a consequence of):

c. PRESUMED LUNG CANCER

UNKNOWN

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD-048322-L

29d. Date signed (Month, Day, Year)

MARCH 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERESA BISNETT, MAJ, USAF, MC

89 MDG/ 1050 W PERIMETER ROAD

ANDREWS AIR FORCE BASE, MD 20762-6600

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

Teresa A. Spence

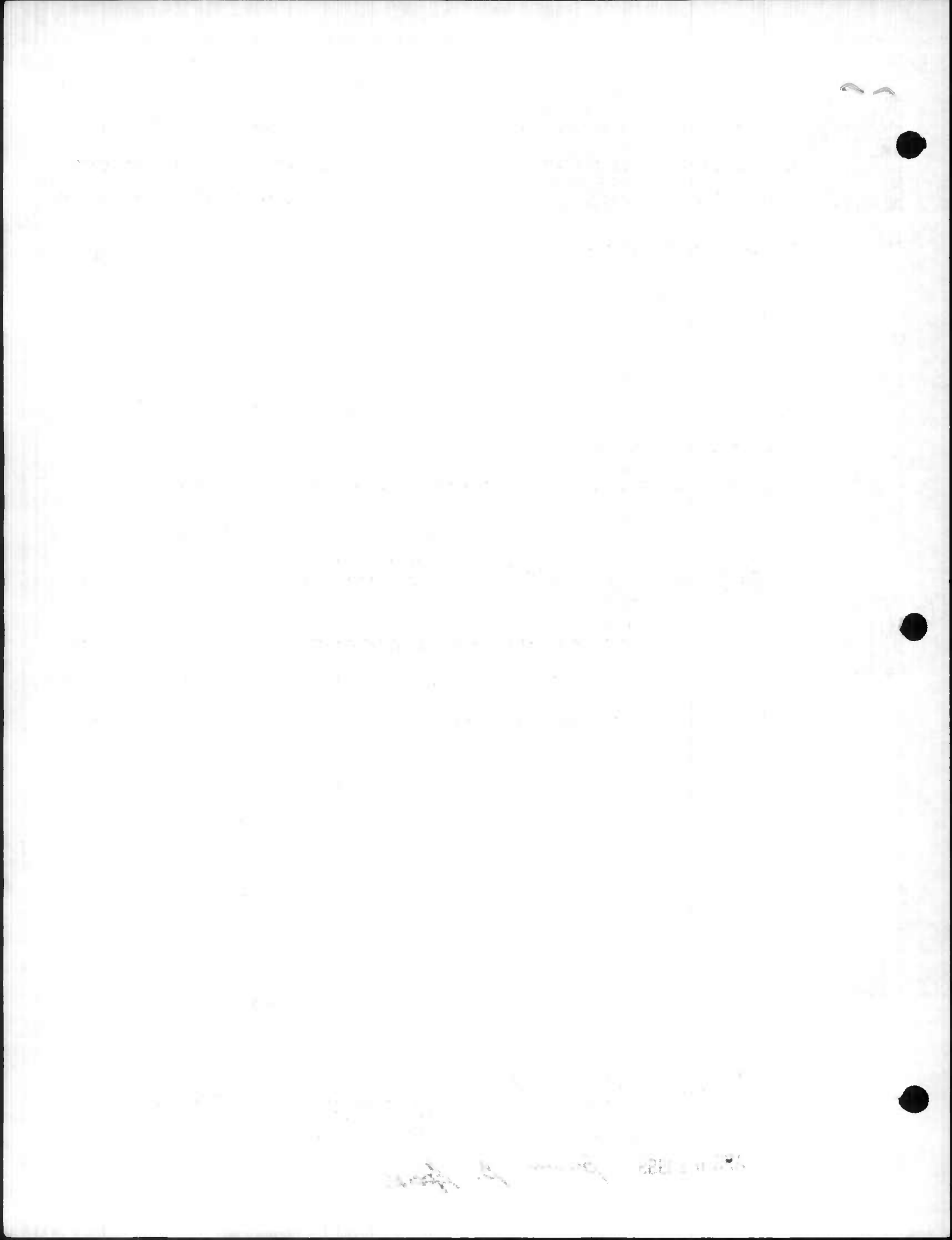
State  
RegistrarBURRELL JONES  
Baltimore, Maryland 21215-00206 1/  
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Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





jhm

JOSEPH BRUCE

JANDA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12378

|   |   |   |  |  |  |  |  |  |   |  |  |
|---|---|---|--|--|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH BRUCE JANDA SR.</b>               |   |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 28, 1999</b>  |  | 3. Time of Death<br><b>09:47 AM</b>                                 |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CUMMINGS CREEK</b> |   |  |  |  |  | 4b. City, Town, or Location of Death<br><b>Wittman</b>   |  | 4c. County of Death<br><b>TALBOT</b>                                |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-68-9281</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>41</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 22, 1951</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>         |  |  |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Talbot</b>                            |  | 10c. City, Town or Location<br><b>Wittman</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 10e. Street and Number<br><b>22850 Pot Pie Rd.</b>  |   |   |  | 10f. Zip Code<br><b>21676</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                             |  |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Waterman</b>                 |  |  | 16b. Kind of Business/Industry<br><b>Seafood</b>   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jerome William Janda Sr.</b>  |   |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna L. Mizell</b> |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lacy Caroline Janda Wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 176 Wittman, Maryland 21676</b> |  |  |  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Tilghman Meth. Cemetery</b>   |  |  | Date<br><b>March 31, 1999</b>  |  | 20c. Location - City or Town, State<br><b>Tilghman, Maryland</b>   |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>               |  |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Drowning</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |  |  |  |  |   | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|   |   |   |  |  |  |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
|   |   |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |  |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |   | 28a. Date of Injury (Month, Day, Year)<br><b>3 27 99</b>   |  | 28b. Time of Injury<br><b>1303 PM</b>  |  | 28c. Injury at Work?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                        |  | 28d. Describe how injury occurred<br><b>SUBJECT FELL OFF A BOAT</b> |  |  |
|   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>BODY OF WATER</b>   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>CUMMINGS CREEK TALBOT CO MD</b> |  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |   |   |  |  |  | 29c. License number<br><b>OCME</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 29, 1999</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wayne B. Kohn 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |  |  |  |  |  |  |   |  |  |
| State Registrar   |   | 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b> |  | 32. Registrar's Signature<br>                            |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12379

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Johnnie J. Johnson

2. Date of Death  
Month Day Year  
MARCH 29, 19993. Time of Death  
09:15 AM

4a. Facility Name (If not institution, give street and number)

1095 COLORA ROAD

4b. City, Town, or Location of Death

Colora

4c. County of Death

CECIL

Funeral  
Director

5. Social Security Number

217-26-8617

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 4, 1931

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Colora

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1095 Colora Rd.

10f. Zip Code

21917

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1953-5613. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Auto Manufacturing

17. Father's Name (First, Middle, Last)

Lee McKinley Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Isabell Murray

19a. Informant's Name/Relationship (Type, Print)

Hazel Johnson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1095 Colora Rd., Colora, MD 21917

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Union Cemetery

Date

4-2-99

20c. Location - City or Town, State

Elkton, Maryland

21. Signature of Funeral Service Licensee

*Richard L. Jordie*

22. Name and Address of Facility

R. T. Foard Funeral Home, P. A.  
111 S. Queen St., Rising Sun, MD 2191123a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Gunshot Wound of Head*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Cancer of Urinary Bladder*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?*partial*  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)  
3/28/99

28b. Time of Injury

300 A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

*self inflicted gunshot wound*28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)*home*28f. Location (Street and Number or Rural Route Number,  
City or Town, State)*1095 Colora Rd  
Colora, Md*29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Dennis J. Chute as*

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MARCH 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Dennis J. Chute, MD* 111 Penn Street, Baltimore, Maryland 21201State  
Registrar

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

*B. Sparks*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

99 12380

Amended Item #8, 3/29/99, per F.D., Carroll County, wjl **Certificate of Death**

Reg. No.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>NORMAN KLEIN</b>                                |   | 2. Date of Death<br>Month <b>3</b> Day <b>25</b> Year <b>99</b>             |  | 3. Time of Death<br><b>3:15pm</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Golden Age Guest Home</b> |   | 4b. City, Town, or Location of Death<br><b>Sykesville</b>                   |  | 4c. County of Death<br><b>Carroll</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>070-10-9442</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.                            | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month/Day/Year)<br><b>Jan. 8, 1901</b>                                       |   | 9. Birthplace (State or Foreign Country)<br><b>NY</b>                       |  |  |
| Usual Residence of Decedent  |  |   |   |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Carroll</b>  | 10c. City, Town or Location<br><b>Sykesville</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>2601 Bomek Circle</b>   |  | 10f. Zip Code<br><b>21784</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br><b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |   |  |  |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>teacher</b>   |  | 16b. Kind of Business/Industry<br><b>education</b>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Klein</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia Sandstrom</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Donald Klein (son)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2601 Bomek Circle, Sykesville MD 21784</b>  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation</b>  |   | 20c. Location - City or Town, State<br><b>3-26-99 Hampstead, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Page Haight Herbert</b>  |  | 22. Name and Address of Facility<br><b>Haight Funeral Home<br/>Box 195 Sykesville, MD 21784</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  | Approximate Interval Between Onset and Death   |
| a. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):   |  |   |   |  | <b>&gt; 1 year</b>   |
| b. <b>Primary Degenerative Dementia</b><br>Due to (or as a consequence of):  |  |   |   |  | <b>&gt; 1 year</b>   |
| c. <b>Prostate Cancer</b><br>Due to (or as a consequence of):  |  |   |   |  | <b>&gt; 1 year</b>   |
| d.   |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how Injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                       |  | 29b. Signature and title of certifier<br><b>Patrick A. Turner MD</b>  |   | 29c. License number<br><b>D20806</b>   | 29d. Date signed (Month, Day, Year)<br><b>3/25/99</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Patrick Turner, MD 1425 LIBERTY RD ELDERSBURG, MD 21784</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>  |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12381

|   |  |   |   |   |  |                                 |                                |   |                                       |   |  |
|---|--|---|---|---|--|---------------------------------|--------------------------------|---|---------------------------------------|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Earl Klapp</b>                            |   |   |   | 2. Date of Death<br>Month Day Year<br><b>March 26 1999</b> |                                 |                                |   | 3. Time of Death<br><b>10:28am</b>    |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7200 Ridge Road</b> |   |   |   | 4b. City, Town, or Location of Death<br><b>Sykesville</b>  |                                 |                                |   | 4c. County of Death<br><b>Carroll</b> |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-14-9375</b>  |   | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b> |   | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.           |                                 | If Under 1 Year<br>Months Days |   | If Under 24 Hrs.<br>Hours Min.        |   |  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Sept 10 1920</b>                               |   |   |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>      |                                 |                                |   |                                       |   |  |
| Usual Residence of Decedent   |  |   |   |   |  |                                 |                                |   |                                       |   |  |
| 10a. State<br><b>Md</b>   |  | 10b. County<br><b>Carroll</b>   |   | 10c. City, Town or Location<br><b>Sykesville</b>  |  |                                 |                                | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |                                       |   |  |
| 10e. Street and Number<br><b>7200 Ridge Road</b>  |  |   |   | 10f. Zip Code<br><b>21784</b>   |  |                                 |                                | 10g. Citizen of What Country?<br><b>USA</b>   |                                       |   |  |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b><br><b>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b><br>If Yes, Give Year or Dates: <b>1944-1946</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:   |  |                                 |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                   |                                       |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>farmer</b>  |  |                                 |                                | 16b. Kind of Business/Industry<br><b>agriculture</b>  |                                       |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Elroy Klapp</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Lillian Isenock</b>   |  |                                 |                                |   |                                       |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Madeline Klapp (spouse)</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7200 Ridge Road, Sykesville, MD 21784</b>   |  |                                 |                                |   |                                       |   |  |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b><br><b>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Highland View Cemetery</b>   |  | Date<br><b>3-29-99</b>          |                                | 20c. Location - City or Town, State<br><b>Berrett, Md.</b>  |                                       |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Brian A. Haight</b>   |  |   |   | 22. Name and Address of Facility<br><b>Haight Funeral Home &amp; Chapel</b><br><b>P.O. Box 195 Sykesville, Md 21784</b>   |  |                                 |                                |   |                                       |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Colonic Adenocarcinoma</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |   |  |                                 |                                |   |                                       | Approximate Interval Between Onset and Death<br><b>3 months</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>None</b>   |  |   |   |   |  |                                 |                                |   |                                       | 23b. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |
| 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |   |   |   |  |                                 |                                |   |                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  |                                 |                                |   |                                       |   |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b><br><b>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</b>  |  |   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b> |                                | 28c. Injury at Work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>               |                                       | 28d. Describe how injury occurred   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                 |                                |   |                                       |   |  |
| 29a. Certifier (Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>   |  |   |   | 29b. Signature and title of certifier<br><b>Dr. Marshall A. Levine, M.D.</b>  |  |                                 |                                | 29c. License number<br><b>D17873</b>  |                                       | 29d. Date signed (Month, Day, Year)<br><b>March 26, 1999</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Marshall A. Levine, 1838 Groentree Rd. Baltimore, Maryland 21208</b>   |  |   |   |   |  |                                 |                                |   |                                       |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  |   |   | 32. Registrar's Signature<br><b>Brian P. Sparks</b>   |  |                                 |                                |   |                                       |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

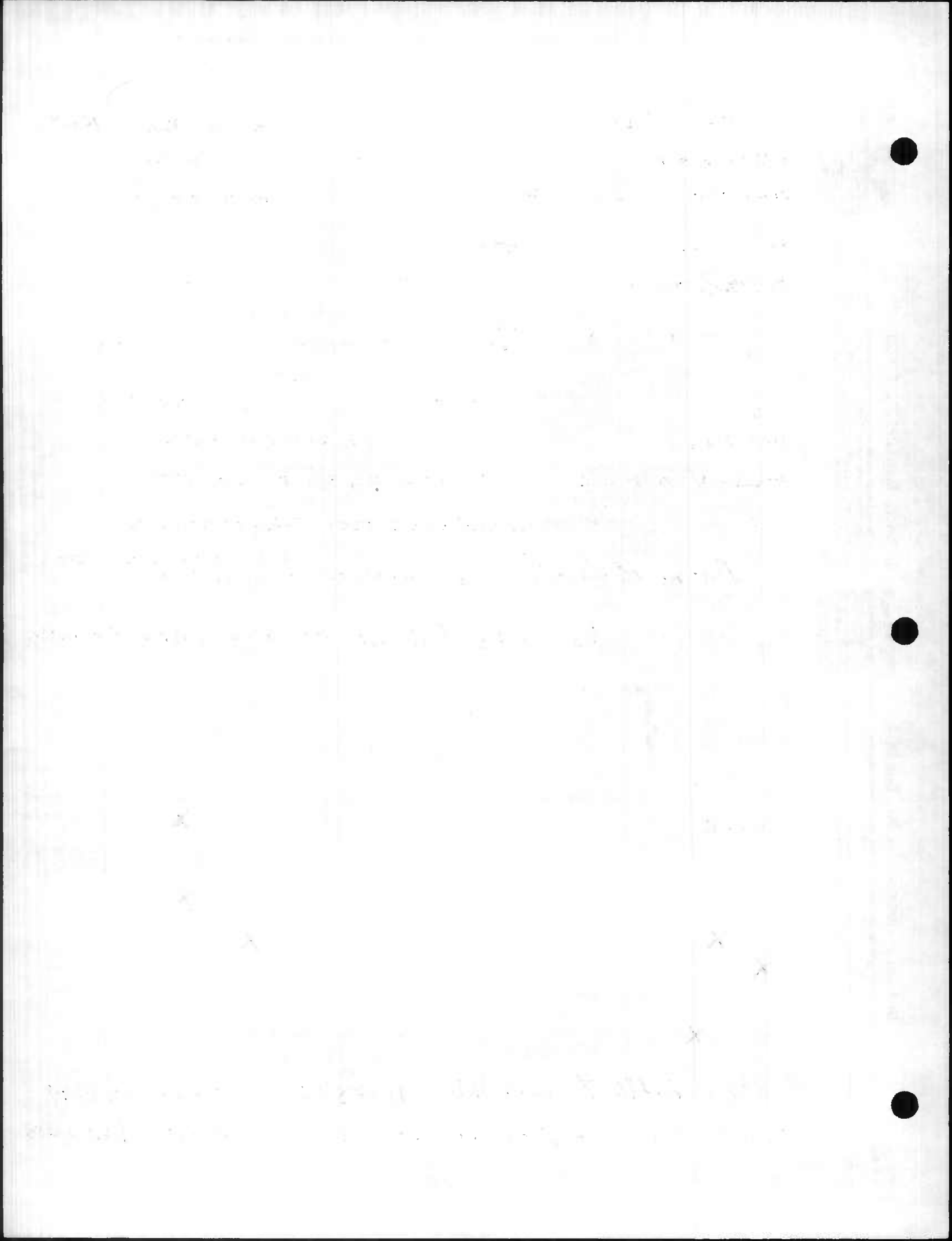
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12382

|   |   |                                      |   |  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
|---|---|--------------------------------------|---|--|--|---|--|---|---|---|----|---------------------|---|----|---------------------|----|-----------------|----|----------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas C. Long</b>                           |                                      |   |  | 2. Date of Death<br>Month Day Year<br><b>March 23 1999</b> |   |  |   | 3. Time of Death<br><b>3:45 AM</b>                                      |   |    |                     |   |    |                     |    |                 |    |                            |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>6712 Dorman Street</b> |                                      |   |  | 4b. City, Town, or Location of Death<br><b>Landover</b>    |   |  |   | 4c. County of Death<br><b>Prince Georges</b>                            |   |    |                     |   |    |                     |    |                 |    |                            |
| Funeral<br>Director   | 5. Social Security Number<br><b>709-05-7595</b>   |                                      | 6. Sex<br><b>1</b> M <b>2</b> F   |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.           |   | 8. Date of Birth (Month, Day, Year)<br><b>July 22 1918</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Mississippi</b>          |   |    |                     |   |    |                     |    |                 |    |                            |
|   | Usual Residence of Decedent   |                                      |   |  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince Georges</b> |   | 10c. City, Town or Location<br><b>Landover</b>   |  |   |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 10e. Street and Number<br><b>6712 Dorman Street</b>   |   |                                      |   | 10f. Zip Code<br><b>20784</b>  |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |   |                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: <b>WWII</b>              |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |    |                     |   |    |                     |    |                 |    |                            |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)  |   |                                      |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bookkeeper</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Accounting</b>   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 17. Father's Name (First, Middle, Last)<br><b>Martin Luther Long, Sr.</b>   |   |                                      |   |  |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Mary Dyer</b>  |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Miriam Messick, Daughter</b>   |   |                                      |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6712 Dorman Str. Landover Md. 20784</b>       |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |   |                                      |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cem.</b>  |  | Date<br><b>3/26/99</b>  |  | 20c. Location - City or Town, State<br><b>Brentwood, Md.</b>  |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 21. Signature of Funeral Service Licensee<br>   |   |                                      |   |  |  | 22. Name and Address of Facility<br><b>Ft. Lincoln F.H.<br/>3401 Bladensburg Rd. Brentwood, Md. 20722</b>   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |                                      |   |  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Heart Attack</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>5 mos</b><br/><br/> <b>10yrs.</b><br/><br/> <b>10 yrs</b><br/><br/> <b>10 yrs</b> </td> </tr> <tr> <td>b.</td> <td><b>Hypertension</b></td> </tr> <tr> <td>c.</td> <td><b>Diabetes</b></td> </tr> <tr> <td>d.</td> <td><b>Atrial Fibrillation</b></td> </tr> </table> |   |                                      |   |  |  |   |  |   |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | <b>Heart Attack</b> | Approximate Interval Between Onset and Death<br><br><b>5 mos</b><br><br><b>10yrs.</b><br><br><b>10 yrs</b><br><br><b>10 yrs</b> | b. | <b>Hypertension</b> | c. | <b>Diabetes</b> | d. | <b>Atrial Fibrillation</b> |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a.  | <b>Heart Attack</b>                  | Approximate Interval Between Onset and Death<br><br><b>5 mos</b><br><br><b>10yrs.</b><br><br><b>10 yrs</b><br><br><b>10 yrs</b> |  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
|   | b.  | <b>Hypertension</b>                  |   |  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
|   | c.  | <b>Diabetes</b>                      |   |  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
|   | d.  | <b>Atrial Fibrillation</b>           |   |  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                                      |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |   |    |                     |   |    |                     |    |                 |    |                            |
|   |   |                                      |   |  |  |   |  | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |   |   |    |                     |   |    |                     |    |                 |    |                            |
|   |   |                                      |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No               |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |   |                                      |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |   |                                      |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |   |   |    |                     |   |    |                     |    |                 |    |                            |
|   |   |                                      |   | 28d. Describe how injury occurred  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
|   |   |                                      |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                                      |   |  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 29b. Signature and title of certifier<br>  |   |                                      |   |  |  | 29c. License number<br><b>D48200</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/26/99</b>   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alec Anders Cunningham Dr. Berwyn Hgts Md.</b>   |   |                                      |   |  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |   |                                      |   | 32. Registrar's Signature<br>  |  |   |  |   |   |   |    |                     |   |    |                     |    |                 |    |                            |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12383

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mattie Lighty

2. Date of Death  
Month Day Year  
March 29, 19993. Time of Death  
8:30 AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Ft. Washington

4c. County of Death

Prince George's

5. Social Security Number

098-20-6629

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10/27/24

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Ft. Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6511 Eagle Way Lane

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Luther Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Ada Brown

19a. Informant's Name/Relationship (Type, Print)

Steven Lighty/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

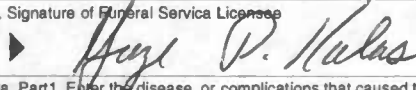
20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veteran's Cemetery 4/6/99 Cheltenham, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

George P. Kalas Funeral Home, P.A.  
6160 Oxon Hill Rd., Oxon Hill, MD 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

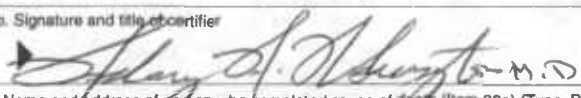
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D32800

29d. Date signed (Month, Day, Year)

March 30, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Hilary H. Washington, MD 11701 Livingston Road Ft. Washington, MD.

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEM: #8 PER F.H. G770 4-21-99 WR.

99 12384

NAME: Leedy, James A.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><u>James A Leedy</u>  |  | 2. Date of Death<br>Month <u>Apr</u> , Day <u>1</u> , Year <u>1999</u>   |  | 3. Time of Death<br><u>12:35 PM</u>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><u>Greater Baltimore Medical Center</u>   |  | 4b. City, Town, or Location of Death<br><u>Towson</u>  |  | 4c. County of Death<br><u>Baltimore</u>  |  |
| 5. Social Security Number<br><u>215-12-5990</u>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><u>79</u> Yrs.                         | 8. Date of Birth (Month, Day, Year)<br><u>JAN. 23 1920</u>   |  |
| 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>   |  | Usual Residence of Decedent  |  |  |  |
| 10a. State<br><u>MD</u>   |  | 10b. County<br><u>Baltimore</u>  |  | 10c. City, Town or Location<br><u>Freeland</u>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 10e. Street and Number<br><u>20422 Slab Bridge Road</u>   |  | 10f. Zip Code<br><u>21053</u>  |  | 10g. Citizen of What Country?<br><u>USA</u>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>WW II</u>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u></u>  |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Machinist</u>   |  | 16b. Kind of Business/Industry<br><u>Manufacturing</u>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>George A. Leedy</u>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Josie M. Dix</u> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Nellie M. Leedy / Wife</u>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>20422 Slab Bridge Road Freeland, MD 21053</u>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Bel Air Memorial Gdns.</u>  |  | 20c. Location - City or Town, State<br><u>Bel Air, MD</u>  |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>   |  | 22. Name and Address of Facility<br><u>J. J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349</u>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><u>Arteriosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of):   |  |  |  |  |  |
| b. Due to (or as a consequence of):   |  |  |  |  |  |
| c. Due to (or as a consequence of):   |  |  |  |  |  |
| d. Due to (or as a consequence of):   |  |  |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><u>M</u>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |  |
| 29b. Signature and title of certifier<br><u>Charles F. O'Donnell MD</u>   |  | 29c. License number<br><u>5-09383</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>April 1, 1999</u>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>Charles F. O'Donnell MD 111 Hamlet Hill Rd Baltimore MD 21210</u>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 8 1999</u>  |  | 32. Registrar's Signature<br><u>[Signature]</u>  |  |  |  |

15

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12385

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JAMES TAYLOR LEDNUM

2. Date of Death

Month Day Year  
MARCH 24 1999

3. Time of Death

11:31 PM

4a. Facility Name (If not institution, give street and number)

21545 MISSION ROAD

4b. City, Town, or Location of Death

TILGHMAN

4c. County of Death

TALBOT

5. Social Security Number

215-12-2924

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 6, 1919

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

TILGHMAN

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

21545 MISSION ROAD

10f. Zip Code

21671

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5College (1-4 or 5+)  
-0-16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

WATERMAN

16b. Kind of Business/Industry

SEAFOOD

17. Father's Name (First, Middle, Last)

DANIEL EDGAR LEDNUM

18. Mother's Name (First, Middle, Maiden Surname)

MARY ALICE FERGUSON

19a. Informant's Name/Relationship (Type, Print)

HELEN L. ROUSE/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6235 CHURCH HOME ROAD, THODESDALE, MD 21659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TILGHMAN WESLEYAN CEMETERY

Date

3-29-99

20c. Location - City or Town, State

TILGHMAN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC PROSTATE CARCINOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26350

29d. Date signed (Month, Day, Year)

3-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM S. BREMER, M.D., 800 S. TALBOT ST., ST. MICHAELS, MD 21663

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12386

|   |  |  |   |  |   |  |  |   |  |  |
|---|--|--|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MARIE J. LONG  |  |   |  |   | 2. Date of Death<br>Month Day Year<br>APRIL 1, 1999  |  | 3. Time of Death<br>6:57 PM   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>3833 ST. BARNABAS ROAD APT. T2   |  |   |  |   | 4b. City, Town, or Location of Death<br>SILVER HILL  |  | 4c. County of Death<br>PRINCE GEORGES   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>579-52-5943   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>60   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>DEC. 24, 1938                                 |   | 9. Birthplace (State or Foreign Country)<br>WASHINGTON, DC |  |
|   | Usual Residence of Decedent  |  |   |  |   |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MARYLAND   |  | 10b. County<br>PRINCE GEORGES   |  | 10c. City, Town or Location<br>SILVER HILL / SUITLAND   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
|   | 10e. Street and Number<br>3833 ST. BARNABAS ROAD   |  |   |  | 10f. Zip Code<br>20746  |  | 10g. Citizen of What Country?<br>UNITED STATES                                       |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                     |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>12TH GRADE  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>BILLING MANAGER |   |  | 16b. Kind of Business/Industry<br>DISTRICT GOVERNMENT                                |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>HARRY E. JONES  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>AMANDA BONDS GREEN  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>JENNIFER M. LAKES / DAUGHTER   |  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3833 ST. BARNABAS ROAD APT. T2, SILVER HILL, MD 20746 |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>CEDAR HILL CEMETERY   |  | Date<br>4/7/99  |  | 20c. Location - City or Town, State<br>SUITLAND, MARYLAND                            |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Lydia C. Thornton Johnson<br>LYDIA C. THORNTON JOHNSON M00583   |  |   |  |   | 22. Name and Address of Facility<br>THORNTON FUNERAL HOME, P.A.<br>3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640   |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. metastatic breast cancer<br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br>5 years |  |   |  |   |  |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how Injury occurred                          |  |
|   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br>D.J. HALDAR MD   |  |  |   |  | 29c. License number<br>D-17605  |  | 29d. Date signed (Month, Day, Year)<br>4/2/99  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>D.J. HALDAR MD CUMTOWN, MD 20735  |  |  |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 06 1999  |  |  |   |  | 32. Registrar's Signature<br>B. Sparks  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



jhm

DORIS CHARLENA

MORAN

ITEMS: #23 PART I B PER MEO G770 4-29-99 WR.

ITEMS: #23 PART I, II, 27 PER MEO G770 4-15-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12387

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS KIRVEN MORAN

2. Date of Death

Month Day Year  
APRIL 04, 1999

3. Time of Death

22:37 PM

4a. Facility Name (If not institution, give street and number)

FORT WASHINGTON MEDICAL CENTER

4b. City, Town, or Location of Death

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

251-21-2725

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

37 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 5, 1962

9. Birthplace (State or Foreign Country)

Florence, S.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10a. Street and Number

700 Mace Drive

10f. Zip Code

20744

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Certified Public Accountant

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Obediah Kirven

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Burrell

19a. Informant's Name/Relationship (Type, Print)

John Moran / Ex-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

525 Bashford Ln. #2 Alexandria, Virginia 22314

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sansbury Cemetery

Date

4/9/99

20c. Location - City or Town, State

Timmons ville, S.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

SUBARACHNOID HEMORRHAGE

Due to (or as a consequence of):

b.

RUPTURED ANEURYSM OF CEREBRAL ARTERY

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

april 05, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date (Month, Day, Year)

APR 08 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12388

|  |  |                                |   |   |  |  |  |  |  |
|--|--|--------------------------------|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>DARREN SYLVESTER MIAH                    |                                |   |   |  | 2. Date of Death<br>Month Day Year<br>MARCH 25, 1999 |  | 3. Time of Death<br>12:20pm                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>6429 Hil Mar Drive |                                |   |   |  | 4b. City, Town, or Location of Death<br>Forestville  |  | 4c. County of Death<br>Prince George's                           |  |
| Funeral<br>Director  | 5. Social Security Number<br>577-82-3390   |                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>37 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Birth (Month, Day, Year)<br>12/24/61  |  | 9. Birthplace (State or Foreign Country)<br>Washington, D.C. |
|  | Usual Residence of Decedent  |                                |   |   |  |  |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Prince George's |   | 10c. City, Town or Location<br>Forestville  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br>6429 Hil-Mar Drive   |  |                                |   |   | 10f. Zip Code<br>20747   |  | 10g. Citizen of What Country?<br>United States   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  |                                |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>U.S. Postal Worker |  |  | 16b. Kind of Business/Industry<br>Government   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Eleman Miah   |  |                                |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Flora Williams  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Flora Miah / Mother  |  |                                |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6429 Hil-Mar Dr. Forestville, Maryland, Md. 20747   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery   |   | Date<br>3/31/99  |  | 20c. Location - City or Town, State<br>Washington, D.C.  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |                                |   |   | 22. Name and Address of Facility<br>Alexander S. Pope Funeral Homes<br>5538 Marlboro Pike/Forestville, Md. 20747   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Respiratory Failure<br>Due to (or as a consequence of):<br><br>Acquired Immunodeficiency Syndrome<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><br>26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><br>27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide<br><br>28a. Date of Injury (Month, Day, Year)<br><br>28b. Time of Injury<br>M<br><br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>28d. Describe how injury occurred<br><br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><br>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><br>29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><br>29b. Signature and title of certifier<br><i>[Signature]</i><br><br>29c. License number<br>D0051411<br><br>29d. Date signed (Month, Day, Year)<br>3/25/99<br><br>30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>SAADIA J. GRIFFITH HOWARD 1221 Mercantile Lane, Largo MD 20774<br><br>31. Date filed (Month, Day, Year)<br>MAR 29 1999<br><br>32. Registrar's Signature<br><i>[Signature]</i> |  |                                |   |   |  |  |  |  |  |

To Be Completed by Funeral Director

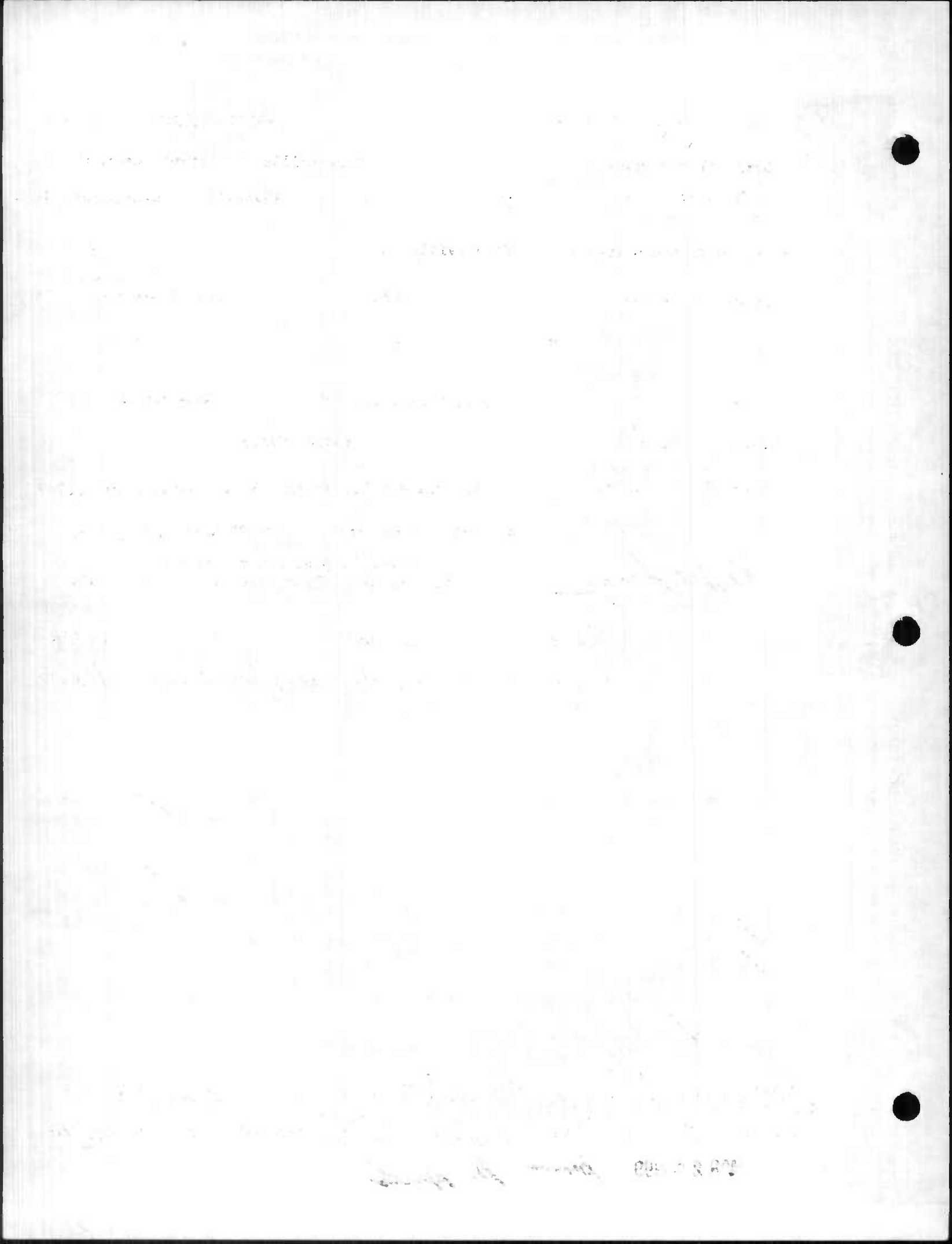
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12389

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Merritt

2. Date of Death

Month 03 Day 25 Year 1999

3. Time of Death

9:00A

4a. Facility Name (If not institution, give street and number)

Future Care Pineview

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

051-12-7903

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 21, 1918

9. Birthplace (State or Foreign Country)

EMPORIA, VA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

WASHINGTON DC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3139 M st. S.E.

10f. Zip Code

20019

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER INTRUSTOR

16b. Kind of Business/Industry

GOVT

17. Father's Name (First, Middle, Last)

PARSON MERRITT

18. Mother's Name (First, Middle, Maiden Surname)

EVA MOORE

19a. Informant's Name/Relationship (Type, Print)

LORETTA YOUNG/ NEICE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3139 M ST. S.E. WASHINGTON DC 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

QUANTICO NATIONAL CEMETERY 4-1-99 TRIANGLE, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

A. J. Mikell

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME  
2617 PENN.AVE S.E. WASHINGTON DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma of the lung. Right

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive heart failure

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Generalized carcinoma metastases

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heavy smoker  
Metastases to liver and  
Adenoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. A. Sayon MD Medical Director

29c. License number

29d. Date signed (Month, Day, Year)

March 27, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

A. A. Sayon MD 4000 Mitchell Rd Bowie Maryland.

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

A. A. Sayon

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12390

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |   |   |  |  |
|--|--|---|---|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ADINA MUNROE   |   |   |   | 2. Date of Death<br>Month Day Year<br>MAR 29 1999  |   | 3. Time of Death<br>8:20 PM   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>NATIONAL NAVAL MEDICAL CENTER  |   |   |   | 4b. City, Town, or Location of Death<br>BETHESDA   |   | 4c. County of Death<br>MONTGOMERY   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>N/A   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>MAR 29 1999  | 9. Birthplace (State or Foreign Country)<br>MARYLAND  |  |  |
|  | Usual Residence of Decedent  |   |   |   |  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND   | 10b. County<br>PRINCE GEO'S   |   | 10c. City, Town or Location<br>HYATTSVILLE  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
|  | 10e. Street and Number<br>1003 ATLEE DRIVE   |   |   | 10f. Zip Code<br>20785  |  | 10g. Citizen of What Country?<br>UNITED STATES  |   |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0 College (1-4or 5+) 0  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>N/A                                      |   | 16b. Kind of Business/Industry   |   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>LINDEN MUNROE   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>SANDRA WALLER   |   |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>SANDRA W. MUNROE   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1003 ATLEE DRIVE, HYATTSVILLE MD 20785 |  |   |   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>NNMC  |   | Date<br>06 APR 99  |   | 20c. Location - City or Town, State<br>BETHESDA   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   | 22. Name and Address of Facility  |  |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. EXTREME PREMATURITY<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |   |   |   |  |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |  |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |   | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                              |   |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |   |   |  |  |
| 29b. Signature and title of certifier<br>CPT, MC, USA  |  |   |   | 29c. License number<br>0101-057093 (VA)   |  | 29d. Date signed (Month, Day, Year)<br>31 Mar 99  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JOHN T. EANES, CPT, MC, USA  |  |   |   |   |  | NATIONAL NAVAL MEDICAL CENTER<br>BETHESDA MD 20889-5600   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 15 1999   |  | 32. Registrar's Signature<br>   |   |   |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SALVATORE - F. MAMONE

2. Date of Death

April 6, 1999

3. Time of Death

8:30 A.M.

4a. Facility Name (If not institution, give street and number)

Charles County Nursing &amp; Rehab Center

4b. City, Town, or Location of Death

Laplata

4c. County of Death

Charles

5. Social Security Number

101-22-9857

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 21, 1931

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Laplata

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

10200 Laplata Road

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No  
If Yes, Give Year or Dates: Unknown13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Technician

16b. Kind of Business/Industry

Air Condition/  
Refrigeration

17. Father's Name (First, Middle, Last)

John Mamone

18. Mother's Name (First, Middle, Maiden Surname)

Angelina Piscitelli

19a. Informant's Name/Relationship (Type, Print)

Peggy E. Mamone/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3035 A October Pl. Waldorf, MD 20602

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Geo. Wash. University  
Medical Center

Date

April 6  
1999

20c. Location - City or Town, State

Washington, DC.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Columbia Mortuary Services, Inc.  
P.O. Box 58007 Washington, D.C. 2003723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

28. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident 6 Investigation  
3 Suicide 6 Could not be  
4 Homicide 6 determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Leatherwood, MD

29c. License number

D0021031

29d. Date signed (Month, Day, Year)

4/6/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Leatherwood PO Box 249 Waldorf Md 20604- 0249

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12392

|  |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES FORMAN MIELKE</b>                                 |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 31, 1999</b> |  | 3. Time of Death<br><b>8:25am</b>                           |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>WILLIAM HILL HEALTH CARE CENTER</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>EASTON</b>       |  | 4c. County of Death<br><b>TALBOT</b>                        |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-03-1544</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 27, 1913</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>TALBOT</b>                                |  | 10c. City, Town or Location<br><b>EASTON</b>                |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1004 S. WASHINGTON ST.</b>   |   | 10f. Zip Code<br><b>21601</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                              |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>-0-</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>RETAILER/DEALER</b>   |  | 16b. Kind of Business/Industry<br><b>FARM EQUIPMENT</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM F. MIELKE</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EMILY DAFFIN</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ISABEL M. WARFIELD/ NIECE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3503 AEBERLE ROAD, EAST NEW MARKET, MD 21631</b>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CTR. 3-31-99 STEVENSVILLE, MD</b>                |   | 20c. Location - City or Town, State                                      |  |
| 21. Signature of Funeral Service Licensee<br><b>M.E. Neumann III CFSP</b>  |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD 21601</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute Renal Failure</b><br>Due to (or as a consequence of):<br><b>Thrombosis of the Aorta</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |   | Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><b>Years</b>   |   |  |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Carcinoma of the larynx</b><br><b>HCD.</b><br><b>Peripheral Vascular Disease</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>William H. Wood Jr. MD</b>  |  | 29c. License number<br><b>1208715</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/31/99</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>WILLIAM H. WOOD, JR., M.D. 506 IDLEWILD AVENUE, EASTON, MD 21601</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>   |  | 32. Registrar's Signature<br><b>James S. Sparks</b>   |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12393

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Curtis R. Moyer, Sr.

2. Date of Death

Month March Day 30 Year 1999

3. Time of Death

2:03 PM

4a. Facility Name (If not institution, give street and number)

Calvert Manor Healthcare Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

5. Social Security Number

160-07-0253

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 4, 1910

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

Chester

10c. City, Town or Location

Oxford

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

51 Pine Street

10f. Zip Code

19363

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Franklin Moyer

18. Mother's Name (First, Middle, Maiden Surname)

Olivia Miller

19a. Informant's Name/Relationship (Type, Print)

Kathleen Davis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

308 Dallam Rd. Newark, DE 19711

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Christ Union Cemetery

Date

4-3-99

20c. Location - City or Town, State

Niantic, PA

21. Signature of Funeral Service Licensee

*Richard L. Goodie*

22. Name and Address of Facility

R. T. Foard Funeral Home, P. A.  
111 S. Queen St., Rising Sun, MD 21911

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Heart failure*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*minutes*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. *ASCD*  
Due to (or as a consequence of):

*years*

c.   
Due to (or as a consequence of):

d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Chronic stenosis*

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide ☐ Homicide  
☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

*Calvert Health Center*

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Dr. R. Taylor Jr.*

29c. License number

*0-11115*

29d. Date signed (Month, Day, Year)

*3-30-99*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Neil R. Taylor Jr.* Rising Sun, MD 21911

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

*B. Sparks*

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12394

|   |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
|---|---|-------------------------------|---|--|--|---|--|--|--|-------------------------------------|--|---|----|-------------------------------|---|----|----------------------------|----|----------------------|----|--------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ernest Kenneth Magaw, Sr.</b>            |                               |   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>April 05 1999</b>                           |  |  | 3. Time of Death<br><b>00:50</b>    |  |   |    |                               |   |    |                            |    |                      |    |              |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital</b> |                               |   |  |  |   | 4b. City, Town, or Location of Death<br><b>Elkton</b>                                |  |  | 4c. County of Death<br><b>Cecil</b> |  |   |    |                               |   |    |                            |    |                      |    |              |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-12-2517</b>   |                               | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs. |   | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |                                     | 8. Date of Birth (Month, Day, Year)<br><b>July 2, 1920</b> |   |    |                               |   |    |                            |    |                      |    |              |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                             |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| Usual Residence of Decedent   |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 10a. State<br><b>Maryland</b>   |   |                               | 10b. County<br><b>Cecil</b>   |  |  | 10c. City, Town or Location<br><b>Elkton</b>  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 10e. Street and Number<br><b>312 North Street</b>   |   |                               |   |  |  | 10f. Zip Code<br><b>21921</b>   |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |   |                               |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Tender</b>  |  |  | 16b. Kind of Business/Industry<br><b>Paper Manufacturing</b>                                       |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 17. Father's Name (First, Middle, Last)<br><b>Earl T. Magaw</b>   |   |                               |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine E. Bullock</b>  |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William A. Magaw, Sr./Son</b>  |   |                               |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>333 Delancy Road, Elkton, Maryland 21921</b>  |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rosebank Cemetery</b>  |  |  | Date<br><b>April 8, 1999</b>  |  |  | 20c. Location - City or Town, State<br><b>Calvert, Maryland</b>                                    |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 21. Signature of Funeral Service Licensee<br><b>Donald S. Hicks</b>   |   |                               |   |  |  | 22. Name and Address of Facility<br><b>Hicks Home for Funerals, P.A.<br/>103 West Stockton Street, Elkton, Maryland 21921</b>   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>hepatic encephalopathy</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><br/><b>1 day.</b></td> </tr> <tr> <td>b.</td> <td><b>Metastatic Ca Liver</b></td> </tr> <tr> <td>c.</td> <td><b>Ca of Bladder</b></td> </tr> <tr> <td>d.</td> <td><b>COPD.</b></td> </tr> </table> |   |                               |   |  |  |   |  |  |  |                                     |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>hepatic encephalopathy</b> | Approximate Interval Between Onset and Death<br><br><b>1 day.</b> | b. | <b>Metastatic Ca Liver</b> | c. | <b>Ca of Bladder</b> | d. | <b>COPD.</b> |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.  | <b>hepatic encephalopathy</b> | Approximate Interval Between Onset and Death<br><br><b>1 day.</b>   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
|   | b.  | <b>Metastatic Ca Liver</b>    |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
|   | c.  | <b>Ca of Bladder</b>          |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
|   | d.  | <b>COPD.</b>                  |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diable mellitus</b><br><b>Coronary artery</b><br><b>Acute M.I.</b>   |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |                               | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                               |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 29b. Signature and title of certifier<br><b>Julius Hsu MD</b>   |   |                               |   |  |  | 29c. License number<br><b>D04823</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>4/6/99</b>   |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JULIUS CHIH HSU MD 223 West main st. - Elkton, MD 21921</b>  |   |                               |   |  |  |   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |
| 31. Date filed (Month, Day, Year)<br><b>APR 06 1999</b>   |   |                               |   |  |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |  |                                     |  |   |    |                               |   |    |                            |    |                      |    |              |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12395

|  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Beatrice C. McKenzie</b>                              |  |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 27. 1999</b> |  | 3. Time of Death<br><b>9:20 PM</b>                         |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>       |  | 4c. County of Death<br><b>Baltimore</b>                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212 74 4541</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>May 18, 1906</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Pa.</b>   |  | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Baltimore</b>                             |  | 10c. City, Town or Location<br><b>Baltimore</b>            |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>8620 Kelso Drive</b>  |  | 10f. Zip Code<br><b>21221</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Domestic</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Clarence Garlitz</b>   |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Stark</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Morris McKenzie (Son)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>201 Hillendale Ave. Baltimore, Md. 21227</b>   |   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Ann's Cemetery</b>  |  | 20c. Date<br><b>3/31/99</b>  |  | 20d. Location - City or Town, State<br><b>Avilton, Md.</b>   |   | 21. Signature of Funeral Service Licensee<br><b>Harry W. Haight</b>  |  |  |
| 22. Name and Address of Facility<br><b>Sykesville, Md. 21784</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>MULTI-ORGAN FAILURE</b>  |  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |
| 23d. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 23e. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24. Was a cause of death certified?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br><b>M</b>   |   | 28b. Time of Injury<br><b>M</b>  |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>D-37254</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3-28-99</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BOON P. LIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204</b>   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  | 33. Registrar's Name<br><b>G. Sparks</b>   |   | 34. Registrar's Title<br><b>Registrar</b>  |  |  |

To Be Completed by Funeral Director

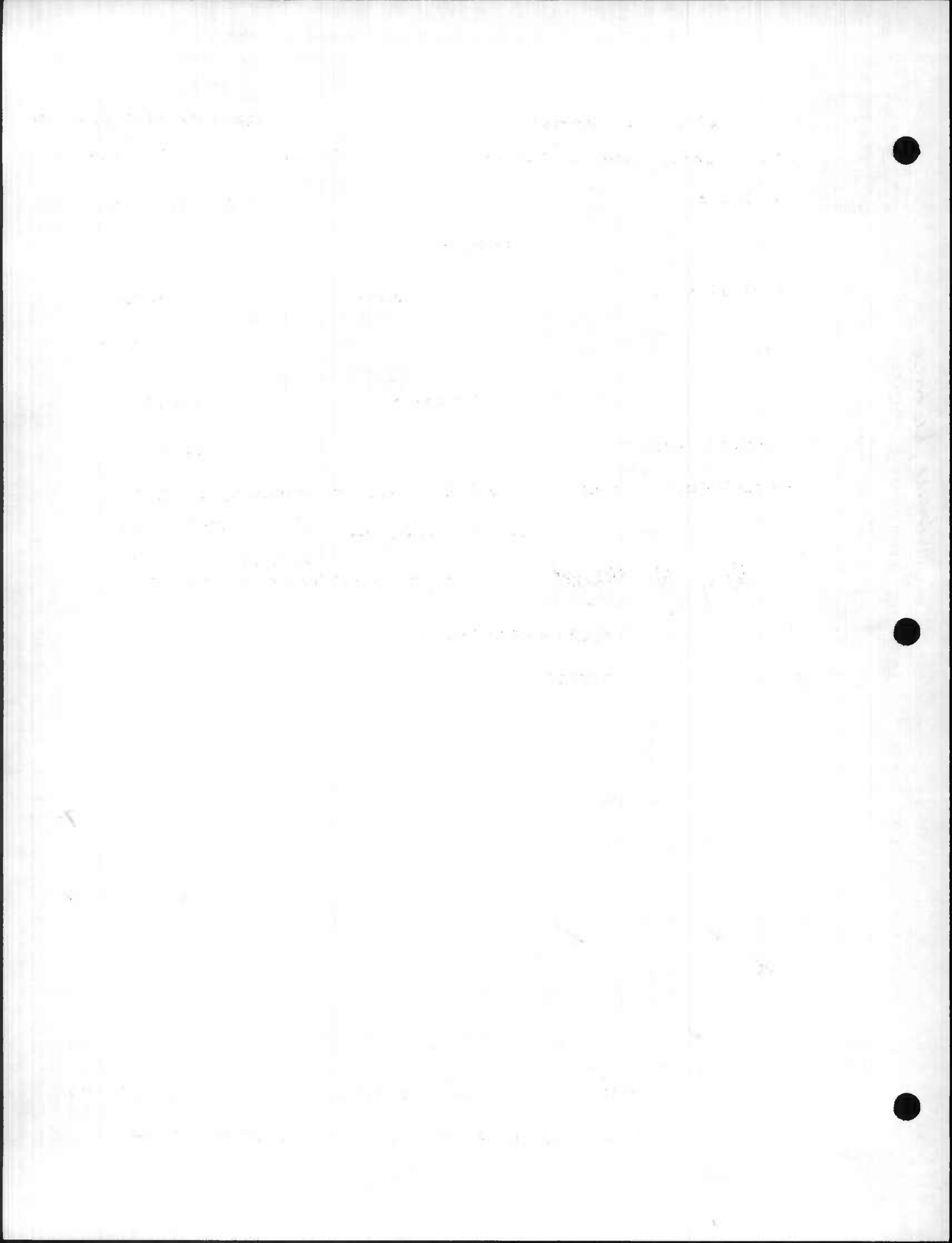
Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12396

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul V. McCracken

2. Date of Death

Month 3 Day 30 Year 99

3. Time of Death

10:40am

4a. Facility Name (If not institution, give street and number)

Baltimore Veterans Administration Medical Center

4b. City, Town, or Location of Death

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

217-16-0983

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10/21/26

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Md

10b. County

Howard

10c. City, Town or Location

Woodbine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5934 Woodbine Road

10f. Zip Code

21797

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1942

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

truck driver

16b. Kind of Business/Industry

transportation

17. Father's Name (First, Middle, Last)

Charles McCracken

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Bradshaw

19a. Informant's Name/Relationship (Type, Print)

Robert McCracken (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 1023 Sykesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

McKendree Cemetery

Date

4-2-99

20c. Location - City or Town, State

West Friendship MD

21. Signature of Funeral Service Licensee

► Page Haight Herbert

22. Name and Address of Facility

Haight Funeral Home & Chapel  
P.O. Box 195 Sykesville, Md 21784

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. pneumonia

Due to (or as a consequence of):

b. lung cancer (poorly differentiated)

Due to (or as a consequence of):

c. squamous cell carcinoma

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 days

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Abigail Drenstein MD MPH

29c. License number

P 12461

29d. Date signed (Month, Day, Year)

3/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abigail Drenstein, 10 North Greenest, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 12397

|   |   |   |  |   |   |  |   |  |
|---|---|---|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Lam Van Nguyen                                      |   |  |   | 2. Date of Death<br>Month Day Year<br>MARCH 30 1999 |  | 3. Time of Death<br>2:50 AM                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Washington Adventist Hospital |   |  |   | 4b. City, Town, or Location of Death<br>Takoma Park |  | 4c. County of Death<br>Montgomery                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>213-37-6809  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>51 Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 3, 1947 |  |
|   | 9. Birthplace (State or Foreign Country)<br>Vietnam   |   | 10a. State<br>Maryland   |   | 10b. County<br>Prince Georges                       |  | 10c. City, Town or Location<br>Lanham               |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 10e. Street and Number<br>9873 Good Luck Rd T-2   |  | 10f. Zip Code<br>20706  |   | 10g. Citizen of What Country?<br>Vietnam   |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Vietnamese                |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) 0  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Maintenance                              |  | 16b. Kind of Business/Industry<br>District Photo  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Nguyen Van Lung  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nguyen Thi Huyen   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Tam Thi Ngo ( Wife )  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9873 Good Luck Rd. T-2 Lanham, MD 20706  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory  |  | 20c. Location - City or Town, State<br>04/01/99 Alexandria, VA  |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |  | 22. Name and Address of Facility<br>Rendon/Hale Funeral Home<br>9013 Annapolis Rd. Lanham, Maryland 20706   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>Hepatocellular cancer</i><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>f.<br>Due to (or as a consequence of):<br>g.<br>Due to (or as a consequence of):<br>h.<br>Due to (or as a consequence of): |   |   |  |   |   |  |   |  |
| 23b. Dld tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |  |   |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |   |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |   |   |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |   |  | 29c. License number<br>B42578   |   | 29d. Date signed (Month, Day, Year)<br>MARCH 31, 1999                                |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>G. CHASE, 1119 Rockwood Pike #316, Rockwood MD 20852  |   |   |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999  |   |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |  |

To Be Completed by Funeral Director

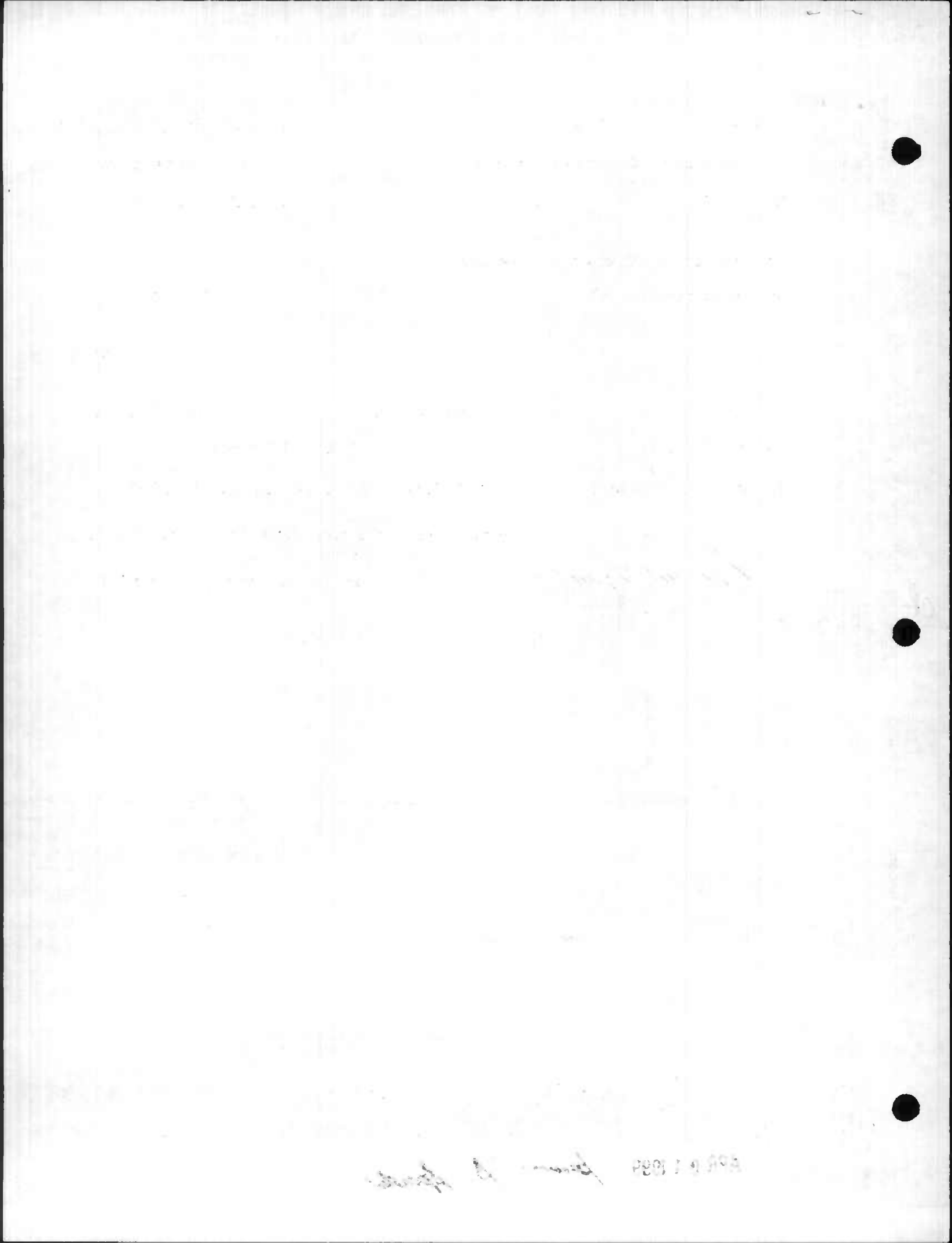
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12398

|  |   |   |  |   |   |  |  |  |
|--|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Naomi Lillian Noel</b>                       |   |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 7 1999</b> |  | 3. Time of Death<br><b>7:10 A.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-26-0156</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 31, 1914</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                              |
|  | Usual Residence of Decedent   |   |  |   |   |  |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Catonsville</b>   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>315 Ingelside Ave.</b>  |   |   |  | 10f. Zip Code<br><b>21228</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |   |   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Operator</b>  |   |  | 16b. Kind of Business/Industry<br><b>Manufacturing</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frederick O. Redman</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Harriet M. Free</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Philip L. Eagan, Sr./Son</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD 1, Box 12, New Freedom, PA 17349</b>   |   |  |  |  |
| 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Bosley United Methodist Church Cemetery</b>   |   | Date<br><b>April 9, 1999</b>   |  | 20c. Location - City or Town, State<br><b>Sparks, MD</b>                                 |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>J.J. Hartenstein Mortuary, Inc.<br/>24 Second St., New Freedom, PA 17349</b>   |   |  |  |  |
| 23e. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>BILATERAL PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>b. <b>RECENT PNEUMONIA WITH LEFT PLEURAL EFFUSION</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><br><b>96 HOURS</b><br><br><b>7 DAYS</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>CORONARY ARTERY DISEASE, PARKINSON'S DISEASE,</b><br><br><b>BIPOLAR DISORDER, TARDIVE DYSKINESIA, RHEUMATIC</b><br><br><b>HEART DISEASE</b>   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><br><b>MEDICAL RESIDENT</b>   |   |   |  | 29c. License number<br><b>P12593</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 7, 1999</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MOHAMMAD V. KHAN, M.D. 900 CATON AVENUE, BALTIMORE, MARYLAND 21229</b>  |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |   |   |  | 32. Registrar's Signature<br>   |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12399

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |   |  |  |
|--|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Geraldine Florence Perry</b>                                     |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>23</b> Year <b>1999</b> |   | 3. Time of Death<br><b>1900</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>DENTON UNIVERSITY OF MARYLAND MEDICINE</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |   | 4c. County of Death  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-26-8167</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>July 20, 1931</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent   |   |  |  |   |   |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Kent</b>  |  | 10c. City, Town or Location<br><b>Worton</b>   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>11040 Plum Drive</b>  |   |   |  | 10f. Zip Code<br><b>21678</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>  |   | 16b. Kind of Business/Industry<br><b>Washington College</b>                                 |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Broadway</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susan Brown</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Perry (husband)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11040 Plum Drive, Worton, Maryland 21678</b>   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pomona Cemetery</b>  |  | Date<br><b>3/29/99</b>   |   | 20c. Location - City or Town, State<br><b>Pomona, Maryland</b>                              |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Bennie Smith Funeral Home<br/>P.O. Box 1687, Easton, Maryland 21601</b>   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Septicemia</b><br>Due to (or as a consequence of):<br>b. <b>pneumonia</b><br>Due to (or as a consequence of):<br>c. <b>Respiratory failure vent dependent</b><br>Due to (or as a consequence of):<br>d. <b>ANOXIC ENCEPHALOPATHY</b> |   |   |  |  |   |   |  | Approximate Interval Between Onset and Death<br><b>2wks</b><br><b>11</b><br><b>3mths</b><br><b>11</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dichloro melliung. chronic renal failure</b><br><b>atherosclerotic heart disease</b>  |   |   |  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 36494</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/24/99</b>                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Heston Denton Medical Center 611 South Charles St Baltimore MD 21200</b>  |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>  |   | 32. Registrar's Signature<br>   |  |  |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12400

|   |   |                                |  |   |  |   |  |  |   |  |
|---|---|--------------------------------|--|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Paul John Phillips                        |                                |  |   |  |   | 2. Date of Death<br>Month Day Year<br>March 25, 1999 |  | 3. Time of Death<br>4:15PM                              |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>2905 Colebrooke Dr. |                                |  |   |  |   | 4b. City, Town, or Location of Death<br>Temple Hills |  | 4c. County of Death<br>Prince George's                  |  |
| Funeral<br>Director   | 5. Social Security Number<br>154-03-4266  |                                | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br>78 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Oct. 19, 1920 |  | 9. Birthplace (State or Foreign Country)<br>W. Virginia |  |
|   | Usual Residence of Decedent   |                                |  |   |  |   |  |  |   |  |
| 10a. State<br>Maryland  |   | 10b. County<br>Prince George's |  | 10c. City, Town or Location<br>Temple Hills   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br>2905 Colebrooke Drive   |   |                                |  |   |  | 10f. Zip Code<br>20748  |  | 10g. Citizen of What Country?<br>U.S.A.  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Ret 1961 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)  |   |                                |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>U.S. Marine Corps  |  |   |  | 16b. Kind of Business/Industry<br>Military   |   |  |
| 17. Father's Name (First, Middle, Last)<br>Alex Phillips  |   |                                |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ethel Jacob  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Victoria Phillips/ Wife   |   |                                |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2905 Colebrooke Dr. Temple Hills, MD 20748 |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cem.   |  | Date<br>4/1/99  |  | 20c. Location - City or Town, State<br>Arlington, VA   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |                                |  |   |  | 22. Name and Address of Facility<br>George P. Kalas Funeral Home, P.A.<br>6160 Oxon Hill Rd. Oxon Hill, MD. 20745                           |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. metastatic non-small cell lung cancer<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |                                |  |   |  |   |  |  |   | Approximate Interval Between Onset and Death<br>2 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                                |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
|   |   |                                |  |   |  |   |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |
|   |   |                                |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                                |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |                                |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
|   |   |                                |  | 28d. Describe how injury occurred   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                                |  | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br>Michigan 4301062644   |   |  |
|   |   |                                |  | 29d. Date signed (Month, Day, Year)<br>26 March 1999  |  |   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Kenneth L. Asboth MD 1050 West Pennington Road Suite 5550 Andrews AFB, MD 20762-6600  |   |                                |  |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 29 1999  |   |                                |  | 32. Registrar's Signature<br>   |  |   |  |  |   |  |

To Be Completed by Funeral Director

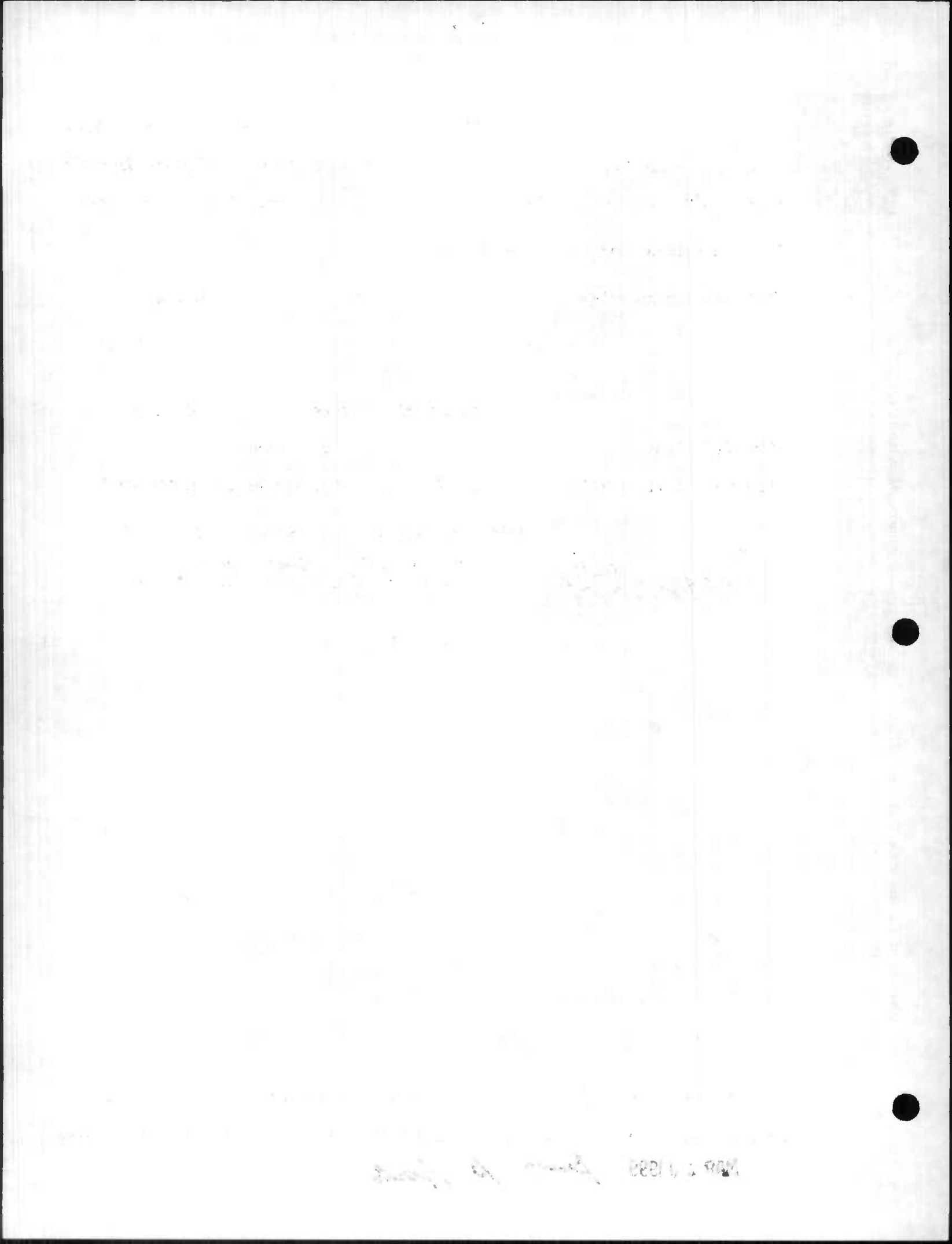
To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12401

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FLORENCE P. PEETE

2. Date of Death

March 26 1999

3. Time of Death

4:26 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

218-16-0308

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 25, 1920

9. Birthplace (State or Foreign Country)

Appomattox, VA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Glendale

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12600 Chalice Court

10f. Zip Code

20769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

RECEPTIONIST

16b. Kind of Business/Industry

Private

Doctor's Offices

17. Father's Name (First, Middle, Last)

WILLIAM A. PANKEY

18. Mother's Name (First, Middle, Maiden Surname)

ALICE JOHNSON

19a. Informant's Name/Relationship (Type, Print)

CAROLYN P. HYATER/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12600 CHALICE CT. GLENDALE, MARYLAND 20769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

4-2-99

20c. Location - City or Town, State

LANDOVER, MARYLAND

21. Signature of Funeral Service Licensee

Shawara L. Blaxton

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME OF MD  
4308 SUTLAND RD. SUTLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Pneumonia

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

rheumatoid arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shawara L. Blaxton MD

29c. License number

D35870

29d. Date signed (Month, Day, Year)

3/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Eckberg M.D. 14300 Gellat Fox Lane #110 Bowie, MD 20715

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

B. Spahr

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12402

|   |   |  |                                 |  |  |   |  |  |
|---|---|--|---------------------------------|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Edward Perry</b>   |  |                                 |  | 2. Date of Death<br>Month <b>03</b> Day <b>25</b> Year <b>99</b> |   | 3. Time of Death<br><b>1559</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Prince Georges Hospital Center</b> |  |                                 |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>          |   | 4c. County of Death<br><b>Prince Georges</b>             |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-64-8004</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F |  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.                 |   | 8. Date of Birth (Month, Day, Year)<br><b>02-11-1948</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Laurel, MS</b>   |  | 10a. State<br><b>DC</b>         |  | 10b. County<br><b>Washington</b>                                 |   | 10c. City, Town or Location<br><b>Washington</b>         |  |
| 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   | 10e. Street and Number<br><b>4419 Brooks Street, NE</b>  |                                 | 10f. Zip Code<br><b>20019</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:                                 |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Security Assistant</b> |                                 | 16b. Kind of Business/Industry<br><b>US Dept. of Justice</b>   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jessie Lee Perry</b>  |   |  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Janie Brown</b>  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia Perry/wife</b>  |   |  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4419 Brooks Street, NE Wash., DC 20019</b>                                   |  |   |  |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Quantico National Cemetery</b>                            |                                 | Date<br><b>3/31/99</b>   |  | 20c. Location - City or Town, State<br><b>Quantico, Virginia</b>        |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Tyrone J. Young</i>   |   | 22. Name and Address of Facility<br><b>Tyrone J. Young Funeral Services</b><br><b>719 Kennedy Street, NW Wash., DC 20011</b>           |                                 |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>unknown</b> |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown                  |                                 |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No                                |                                 |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |   |  |                                 | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |   | 28a. Date of Injury (Month, Day, Year)   |                                 | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><b>Dawn M. Carroll</b>  |                                 | 29c. License number<br><b>D42719</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/25/99</b>                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dawn M. Carroll, MD</b><br><b>Prince Georges Hospital Ctr 3001 Hospital Drive Cheverly, Md 20785</b>   |   |  |                                 |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |   | 32. Registrar's Signature<br><i>Bruce A. Spauld</i>  |                                 |  |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

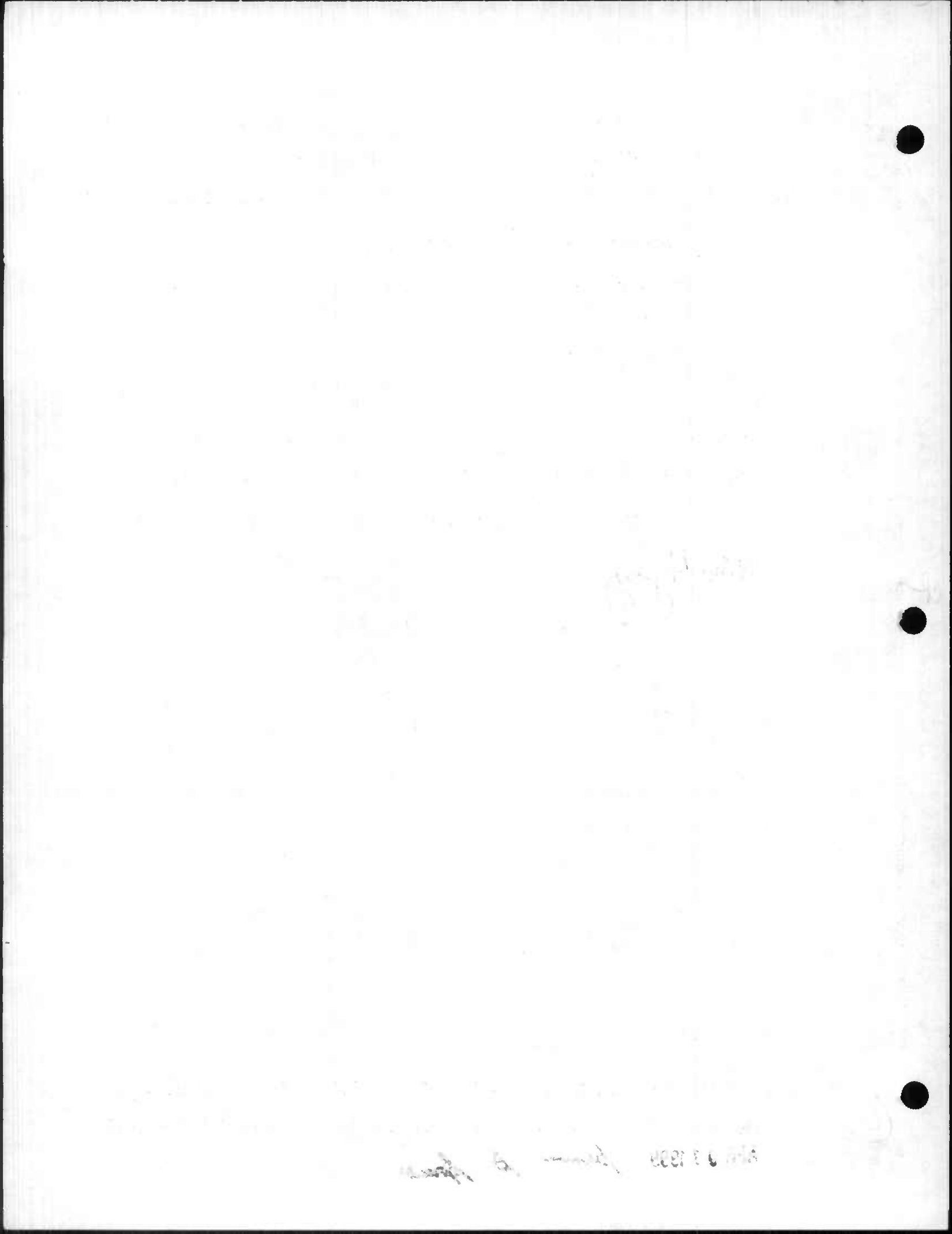
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.



99 12403

DHMH 16 Rev 6/95



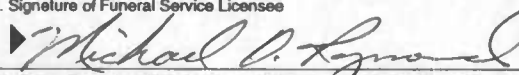

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12404

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>DAVID THOMAS PILAR</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 02, 1999</b>  |  | 3. Time of Death<br><b>9:00 A.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>6315 Teaberry Lane</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |  | 4c. County of Death<br><b>Prince George's</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-98-0599</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>18</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 5, 1981</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>PRINCE GEORGE</b>  |  | 10c. City, Town or Location<br><b>CLINTON</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>6315 TEABERRY WAY</b>  |  | 10f. Zip Code<br><b>20735</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>STUDENT</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HIGH SCHOOL</b>   |  | 16b. Kind of Business/Industry<br><b>HIGH SCHOOL</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>ROBERT JOSEPH TOPPI</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LANI LEI PILAR</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>JAIME R. PILAR FATHER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS #10</b>  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                     |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETS. CEMETERY</b>   |  | 20c. Date<br><b>4-7-99</b>  |  | 20d. Location - City or Town, State<br><b>CHELTENHAM, MARYLAND</b>   |  | 21. Signature of Funeral Service Licensee<br>   |  |
|   | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL SERVICE, P.A.<br/>LA PLATA, MARYLAND 20646</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hanging</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Due to (or as a consequence of):</b><br><br><b>Due to (or as a consequence of):</b><br><br><b>Due to (or as a consequence of):</b> |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><b>Yes</b> 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>Yes</b> 2 <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)<br><b>April 2-99</b>  |  | 28b. Time of Injury<br><b>8:54</b> M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>subject hanged self</b>   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>home</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Clinton, P.G., Md</b>  |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and Title of certifier<br>  |  |
|   | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 03, 1999</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chuter</b><br><b>111 Penn Street, Baltimore, Maryland 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 05 1999</b>   |  |
| State Registrar                               | 32. Registrar's Signature<br>  |  | 33. Date of Death<br><b>APR 02 1999</b>   |  | 34. Time of Death<br><b>9:00 A.M.</b>  |  | 35. Place of Death<br><b>CLINTON, P.G., MD</b>  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12405

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Georgia M. Petrow

2. Date of Death

Month

Day

Year

April

4

1999

3. Time of Death

1840

4e. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

414-38-2035

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 26, 1926

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

22 Apache Place

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Textile

17. Father's Name (First, Middle, Last)

Charlie Staggs

18. Mother's Name (First, Middle, Maiden Surname)

Eler Dugger

19e. Informant's Name/Relationship (Type, Print)

Marian S. Knowles/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Apache Place, Elkton, Maryland 21921

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Holy Sepulchre  
Cemetery

Date

April 8,  
1999

20c. Location - City or Town, State

Cheltenham,  
Pennsylvania

21. Signature of Funeral Service Licensee

Doreen S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 West Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28e. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Hickson Sim

29c. License number

D46412

29d. Date signed (Month, Day, Year)

4/5/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Hickson Sim 314 S. Union Ave Haver No 61212 MP

31. Date filed (Month, Day, Year)

APR 06 1999

32. Registrar's Signature

G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12406  
Certificate of Death

Reg. No.

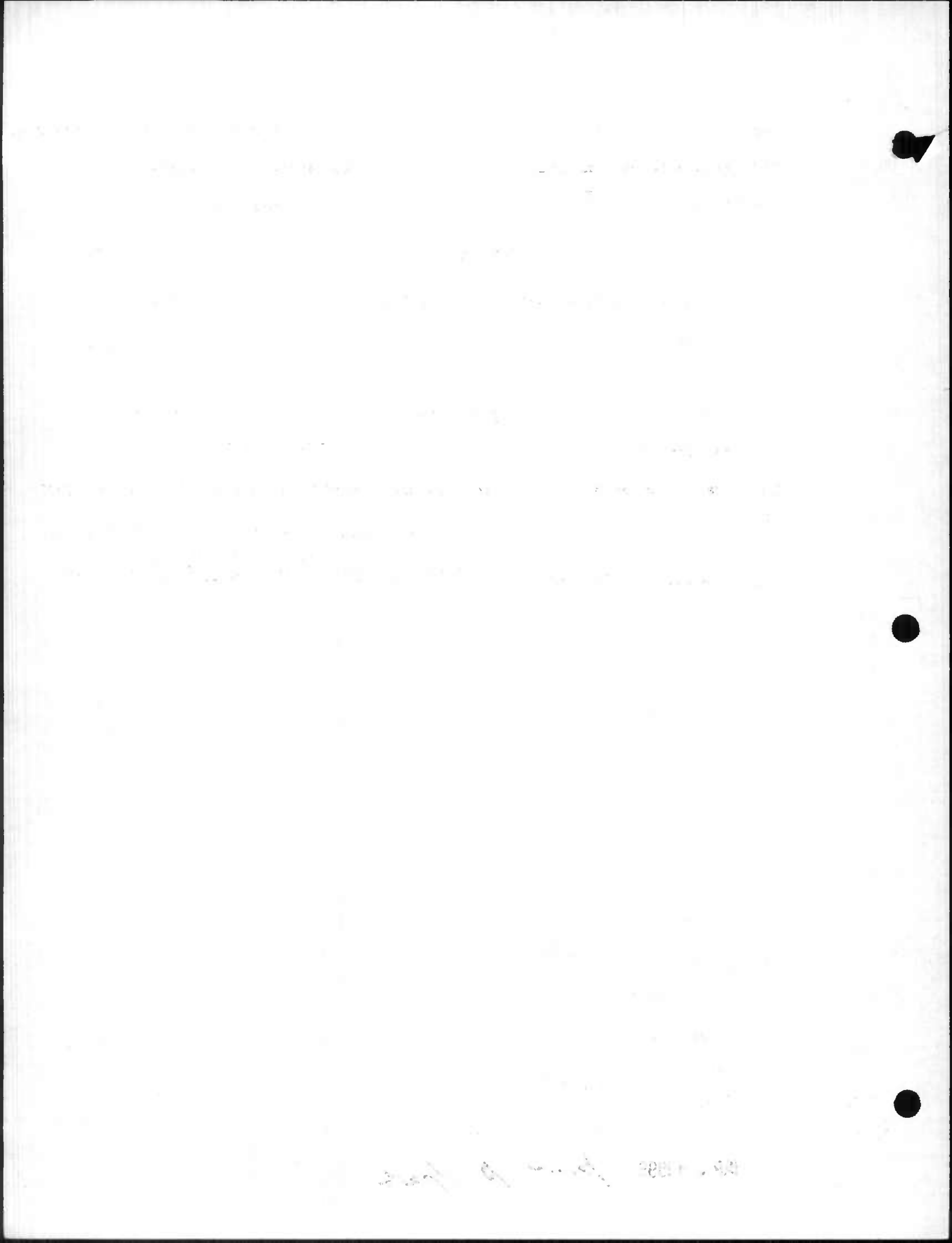
|  |   |   |  |  |   |  |  |  |
|--|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Agatha Castillo Rumingan</b>                           |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>99</b> |  | 3. Time of Death<br><b>4:30 P.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Mariner Health of Kensington</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Kensington</b>           |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-11-3458</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   | If Under 1 Year<br>Months Days                                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>01/27/27</b>   | 9. Birthplace (State or Foreign Country)<br><b>Philippine</b>  |
|  | Usual Residence of Decedent   |   |  |  |   |  |  |  |
| 10a. State<br><b>D.C.</b>  |   | 10b. County   |  | 10c. City, Town or Location<br><b>Washington</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1429 Columbia Road N.W. #B-1</b>  |   |   |  | 10f. Zip Code<br><b>20009</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Filipino</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Herman Castillo</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gabriel Emiliana</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Theodore O. Rumingan</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1429 Columbia Road N.W. #B-1 Washington, D.C. 20009</b>                                  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Haven Cemetery</b>   |  | Date<br><b>03/31/99</b>  |   | 20c. Location - City or Town, State<br><b>Silver Spring, Md.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Wanda C. Bacon</b>   |   |   |  | 22. Name and Address of Facility<br><b>W.H. Bacon Funeral Home<br/>3447 14th Street N.W. Washington, D.C. 20010</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Parkinsonism</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Multiple Decubitus.</b>   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br><b>Aray Reddy</b>  |  | 29c. License number<br><b>D0053691</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARAY REDDY, 3000 McComb's Ave Kensington, MD. 20895.</b>  |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>  |   | 32. Registrar's Signature<br><b>B. Spach</b>  |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

AMENDED, #16a &amp; 16b, 4/1/99, SRR, TALBOT

## Certificate of Death

Reg. No. 99 12407

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Susan King Reed

2. Date of Death  
Month Day Year  
March 27 19993. Time of Death  
6:05 PM

4a. Facility Name (If not institution, give street and number)

Genesis ElderCare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

579-52-8831

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 29, 1926

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

St. Michaels

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Water St.

10f. Zip Code

21663

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No U.S.  
If Yes, Give Year or Dates: Navy

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Innkeeper

16b. Kind of Business/Industry

Bed &amp; Breakfast

U.S. Navy Ret.

17. Father's Name (First, Middle, Last)

Harry Ernest Reed

18. Mother's Name (First, Middle, Maiden Surname)

Florence Evans

19a. Informant's Name/Relationship (Type, Print)

Sally Reed Dunton Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21663

8670 Bozman-Neavitt Rd. St. Michaels, Maryland

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Capitol Crematory March 29, 1999 Dover, Delaware

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Harrison E. Leonard

22. Name and Address of Facility

Harrison E. Leonard Funeral Home 312 S. Talbot  
St. Michaels, Maryland 21663

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acute renal failure

Due to (or as a consequence of):

b.

Chronic renal insufficiency

Due to (or as a consequence of):

c.

Hypertension

Due to (or as a consequence of):

d.

Atherosclerosis, generalized

Approximate interval Between Onset and Death

days  
years  
years  
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harrison E. Leonard

29c. License number

DZ5933

29d. Date signed (Month, Day, Year)

3.28.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL CROWLEY MD 508 IDLEWILD AVENUE EASTON, MD 21601

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

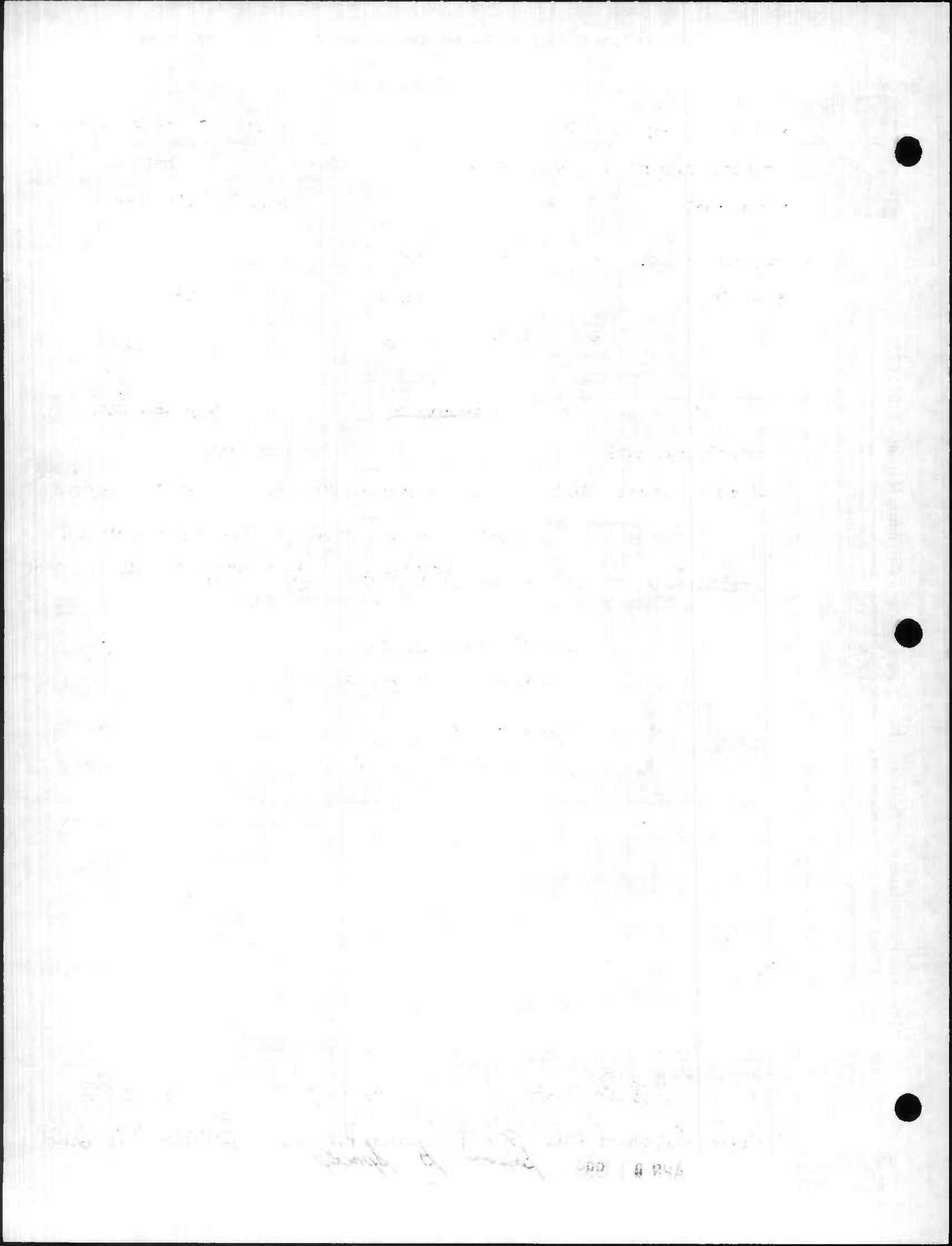
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12408

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HENRY HEATH REESER, SR.

2. Date of Death

MAR. 26, 1999

3. Time of Death

0652

4a. Facility Name (If not institution, give street and number)

THE MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral  
Director

5. Social Security Number

220-28-2696

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 11, 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MD

10b. County

TALBOT

10c. City, Town or Location

TILGHMAN

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5873 SOUTH GIBSONTOWN ROAD

10f. Zip Code

21671

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1945-195213. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
-0-16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

OWNER

16b. Kind of Business/Industry

MARINA/BOAT REPAIR

17. Father's Name (First, Middle, Last)

DR. GUY M. REESER, III

18. Mother's Name (First, Middle, Maiden Surname)

BOBBIE NELL PRICE

19e. Informant's Name/Relationship (Type, Print)

EVELYN E. REESER/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 234, GIBSONTOWN ROAD, TILGHMAN, MD 21671

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

WOODLAWN MEMORIAL PARK

Date

3-30-99

20c. Location - City or Town, State

EASTON, MD

21. Signature of Funeral Service Licensee

M. E. Neenan

C.F.S.P.

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.  
200 S. HARRISON ST., EASTON, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. atherosclerotic heart disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

year

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Hyperlipidemia

Due to (or as a consequence of):

year

c. Hypertension

Due to (or as a consequence of):

year

d. cerebrovascular accident

year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ OIA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Syed I. Ali

29c. License number

D 46020.

29d. Date signed (Month, Day, Year)

3/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED I. ALI, M.D., 506 IDLEWILD AVENUE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

Syed I. Ali

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12409

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JEAN BALLINGER RAUCH</b>                        |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>29</b> Year <b>1999</b> |  | 3. Time of Death<br><b>2359</b>                               |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>The Memorial Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Easton</b>                 |  | 4c. County of Death<br><b>Talbot</b>                          |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>209-36-6185</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 15, 1923</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>                                |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>TALBOT</b>  |  | 10c. City, Town or Location<br><b>EASTON</b>                  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>27461 TRAVELERS REST COURT</b>  |  | 10f. Zip Code<br><b>21601</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4or 5+) <b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>ROBERT IRVING BALLINGER</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES ELIZABETH TAYLOR</b>   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>THOMAS M. RAUCH/ HUSBAND</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27461 TRAVELER'S REST COURT, EASTON, MD 21601</b>  |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CTR</b>  |  | Date<br><b>3-31-99</b>   |   | 20c. Location - City or Town, State<br><b>STEVENSVILLE, MD</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Matthew J. Fischer</i> CFSP   |  |  |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME, P.A.<br/>200 S. HARRISON ST., EASTON, MD 21601</b>   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. myocardial infarction</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. congestive heart failure</b><br>Due to (or as a consequence of):<br><b>c. chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 hour</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>congestive heart failure</b><br><b>chronic obstructive pulmonary disease</b>   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><i>Matthew J. Fischer MD</i>   |  |  |  | 29c. License number<br><b>D52251</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/30/99</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MATTHEW J. FISCHER, M.D., 505 DUTCHMAN'S LANE, EASTON, MD 21601</b>  |  |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |  | 32. Registrar's Signature<br><i>Beverly B. Sparks</i>  |  |  |   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12410

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |                                |  |  |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>William Alexander Smith</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1999</b>  |                                | 3. Time of Death<br><b>9:45 pm</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |                                | 4c. County of Death<br><b>Prince Georges</b>   |  |
| 5. Social Security Number<br><b>230-12-6211</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 1, 1919</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  |   |  |  |                                |  |  |
| Usual Residence of Decedent  |  |   |  |  |                                |  |  |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Prince Georges</b>  |  | 10c. City, Town or Location<br><b>Suitland</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>3723 Demming Drive</b>  |  |   |  | 10f. Zip Code<br><b>20746</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>42-46</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Offset Pressman</b>  |                                | 16b. Kind of Business/Industry<br><b>Gov.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Smith</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Ellis</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Willa Rumphs Niece</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3723 Demming Dr. Suitland, Md. 20746</b>   |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Washington Nat'l Cem</b>   |  | Data<br><b>4/1/99</b>  |                                | 20c. Location - City or Town, State<br><b>Suitland, Md</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>F. Bernard Hunt</b>  |  |   |  | 22. Name and Address of Facility<br><b>Hunt Funeral Home<br/>908 Kennedy St. N.W. Wash. D.C. 20011</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CCF, Cerebrovascular Amyloidosis</b><br>Due to (or as a consequence of):<br><b>b. Peptic ulcer (Peptic ulcer)</b><br>Due to (or as a consequence of):<br><b>c. Renal failure</b><br>Due to (or as a consequence of):<br><b>d. B-sphere</b> |  |   |  |  |                                | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD, CCF, HGB</b>  |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><b>F. Bernard Hunt</b>  |  |   |  | 29c. License number<br><b>D53219</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>9-27-99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ABULHASAN O ANSARI MD<br/>0926 Woodland Rd #101<br/>Clinton Md 20735</b>  |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 02 1999</b>  |  |   |  | 32. Registrar's Signature<br><b>P. Smith</b>   |                                |  |  |

To Be Completed by Funeral Director

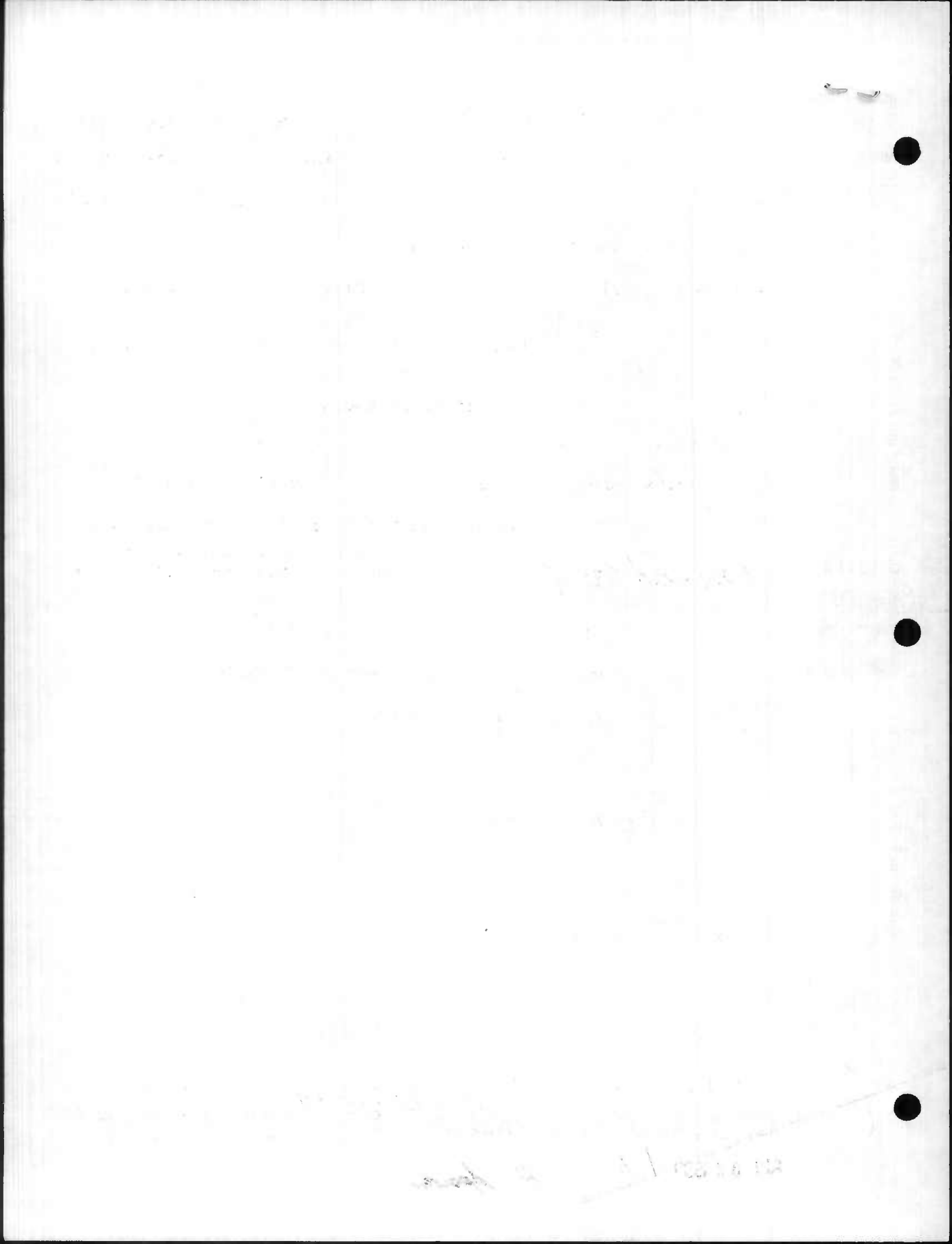
To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12411

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |   |  |                                |  |  |
|--|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>EDWARD B. SLOAN  |  |   |   | 2. Date of Death<br>Month Day Year<br>March 26, 1999   |                                | 3. Time of Death<br>5:10 A.M.  |  |
| 4a. Facility Name (If not institution, give street and number)<br>MARINER HEALTH CARE  |  |   |   | 4b. City, Town, or Location of Death<br>Laurel   |                                | 4c. County of Death<br>Prince Georges  |  |
| 5. Social Security Number<br>050-28-5973   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>80 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>NOV 12, 1918  |  |
| 9. Birthplace (State or Foreign Country)<br>North Carolina   |  |   |   |  |                                |  |  |
| Usual Residence of Decedent  |  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Prince Georges   |   | 10c. City, Town or Location<br>Capitol Heights   |                                |  |  |
| 10e. Street and Number<br>7309 Walker Mill Road  |  |   |   | 10f. Zip Code<br>20743   |                                | 10g. Citizen of What Country?<br>United States   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver  |                                | 16b. Kind of Business/Industry<br>Transportation   |  |
| 17. Father's Name (First, Middle, Last)<br>unknown   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sadie Harvell   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Denise Garrett / Daughter  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7309 Walker Mill Rd., Capitol Heights, Md. 20743  |                                |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory Inc.   |   | Date<br>4/3/99   |                                | 20c. Location - City or Town, State<br>Beltsville, Md.   |  |
| 21. Signature of Funeral Service Licensee<br>Alex S. Pope M859   |  |   |   | 22. Name and Address of Facility<br>ALEXANDER S. POPE FUNERAL HOMES<br>2617 Pennsylvania Avenue, SE DC 20020   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Metastatic colon cancer<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |  |                                |  |  |
| Approximate Interval Between Onset and Death<br>months   |  |   |   |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |   |  |                                | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |   |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |                                |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |                                |  |  |
| 29b. Signature and Title of Certifier<br>[Signature]   |  |   |   | 29c. License number<br>D41978  |                                | 29d. Date signed (Month, Day, Year)<br>3-30-99   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>N. Tavaroz M.D. PGH Chevy M.D. 20785   |  |   |   |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999   |  | 32. Registrar's Signature<br>[Signature]  |   |  |                                |  |  |

To Be Completed by Funeral Director

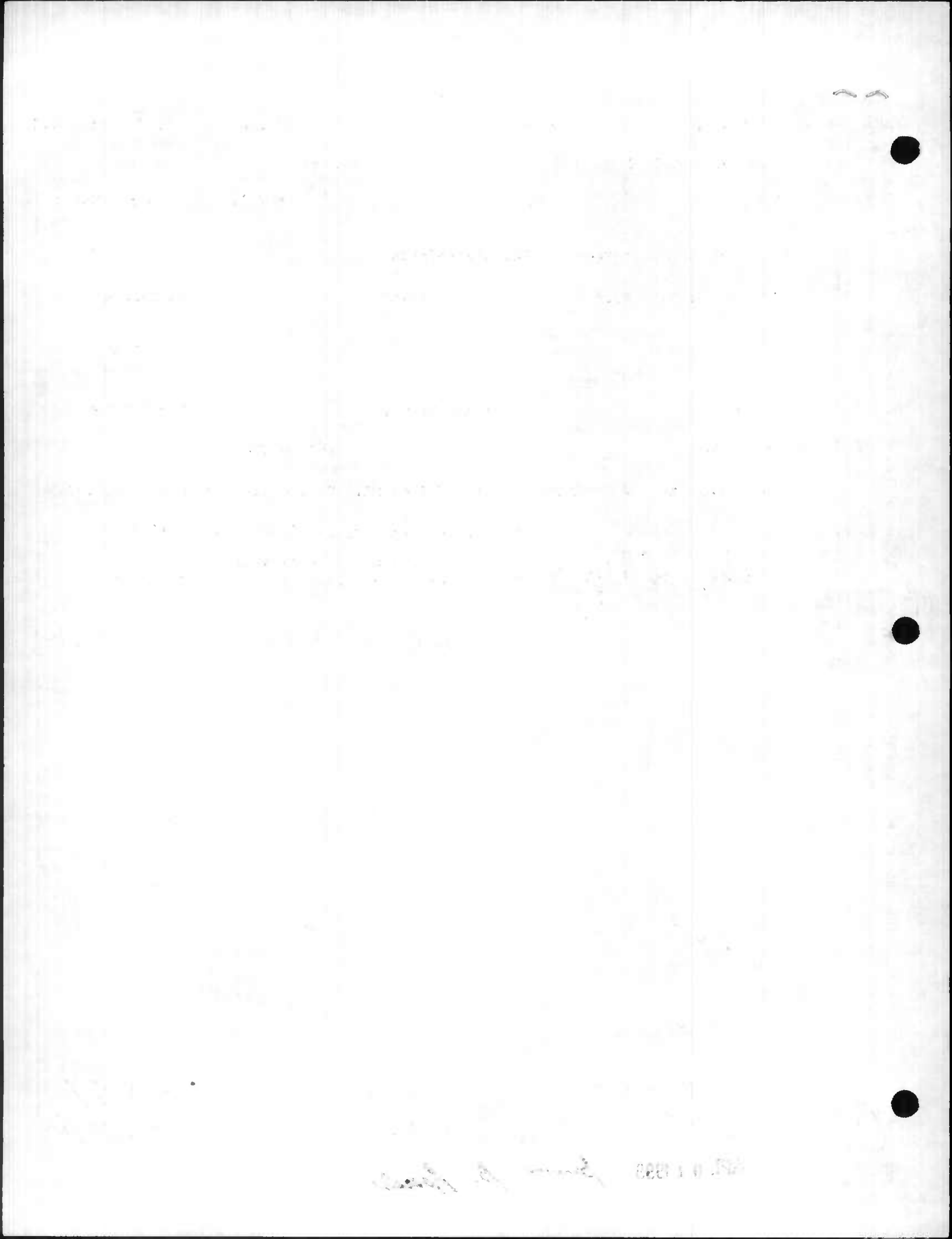
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12412

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Jane Gayle Sontheimer

2. Date of Death

March 24, 1999

3. Time of Death

2:00PM

4a. Facility Name (If not institution, give street and number)

12604 Bridgeton Drive

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

491-09-9257

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 9, 1909

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7600 Morningside Drive NW

10f. Zip Code

20012

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry Lacroix

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Graham

19a. Informant's Name/Relationship (Type, Print)

Doug Sontheimer-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12604 Bridgeton Dr., Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Columbia Gardens

Date

3/26/99

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons INC, 5130 Wisconsin Ave.  
NW, Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Cerebrovascular Accident

1 Week

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)Sons  
Residence

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

0101023985

29d. Date signed (Month, Day, Year)

3-25-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Bruce E. Lessin MD., 1313 Dolly Madison Blvd #207 McLean, VA 22101

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

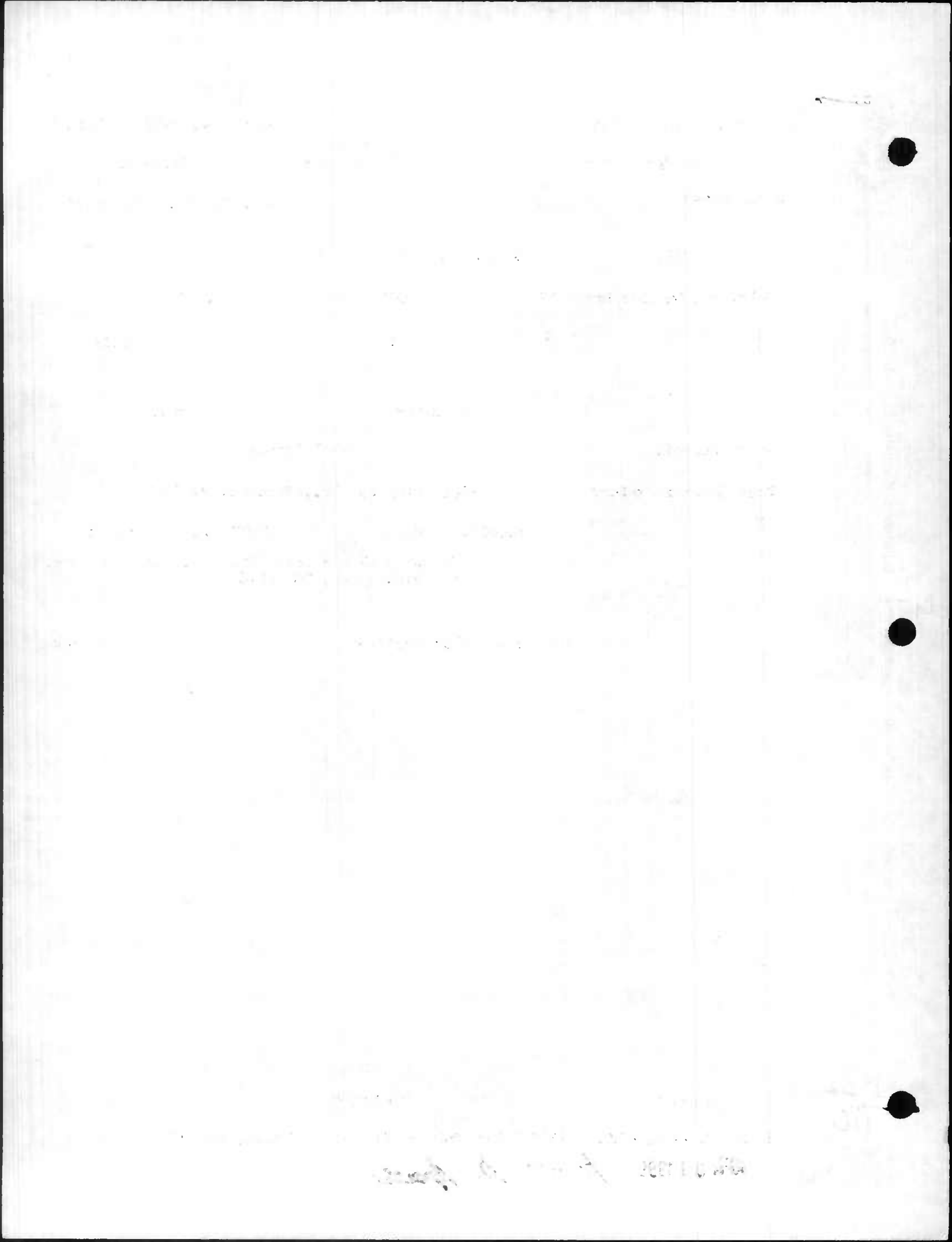
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Cecil County State of Maryland / Department of Health and Mental Hygiene  
Amended Item 10c, 4/6/99, bam

99 12413

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eugene Sewell

2. Date of Death

Month April Day 01 Year 1999

3. Time of Death

1338

4a. Facility Name (If not institution, give street and number)

Baltimore VA Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

—

Funeral  
Director

5. Social Security Number

220-18-9526

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 9-14-1927

9. Birthplace (State or Foreign Country)

Elkton, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Elkton

Chesapeake City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

105 Pine St.

10f. Zip Code

21915

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 11-3-50

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

equipment operator

16b. Kind of Business/Industry

Constructor

17. Father's Name (First, Middle, Last)

Perry Henry Sewell

18. Mother's Name (First, Middle, Maiden Surname)

Edna Hughes

19a. Informant's Name/Relationship (Type, Print)

A. Ronell Young

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 Pine St. Chesapeake City, MD 21915

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DE Vets Memorial Cemetery

Date

4-12-99

20c. Location - City or Town, State

Bear, DE

21. Signature of Funeral Service Licensee

*Robert D. Wright*

22. Name and Address of Facility

The House of Wright Mortuary

208 E. 35th Street Wilm., DE 19802

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Approximate Interval Between Onset and Death

7 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Laryngeal Paralysis

45 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Sgt M D*

29c. License number

P1310630

29d. Date signed (Month, Day, Year)

April 01, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sandra Erhart MD BUAMC 16 N. Greene St., Baltimore, MD 21209

31. Date filed (Month, Day, Year)

APR 06 1999

32. Registrar's Signature

*R. Sparks*

State Registrar

Baltimore, Maryland 21215-0020

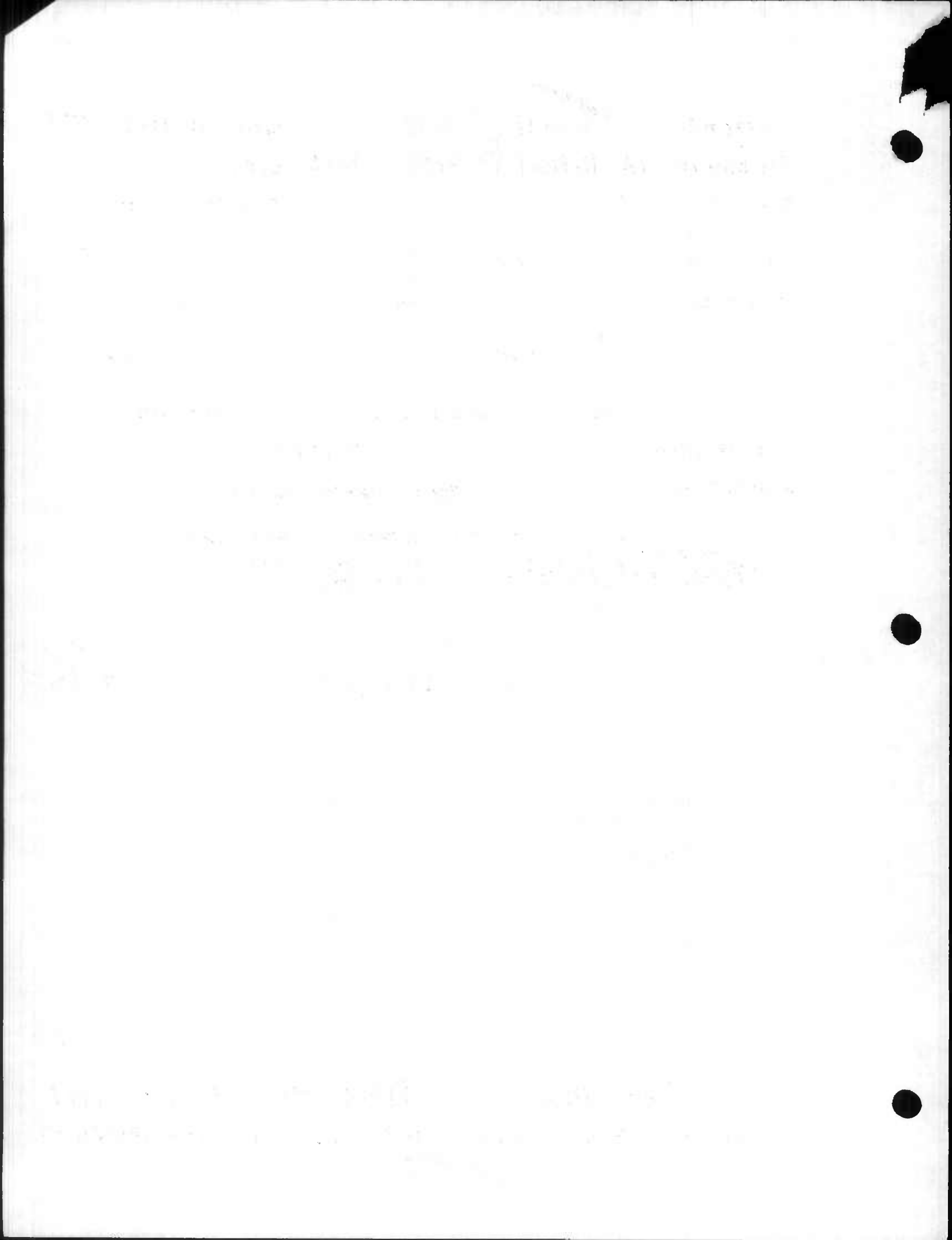
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2+1/4





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Itzie N. Schoenberg

2. Date of Death

Month Day Year  
March 27 1999

3. Time of Death

2122

4a. Facility Name (If not institution, give street and number)

Kent &amp; Queen Anne's Hospital

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

222-07-7987

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 8, 1924

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

DE

10b. County

New Castle

10c. City, Town or Location

Newport

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

221 Christian Street

10f. Zip Code

19804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Musician

16b. Kind of Business/Industry

Entertainment

17. Father's Name (First, Middle, Last)

Morris Schoenberg

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Drucker

19a. Informant's Name/Relationship (Type, Print)

Susan Hogan - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

412 Kissel Ave., Stanton Island, NY 10301

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Jewish Community Cemetery

Date

20c. Location - City or Town, State

Wilmington, DE

21. Signature of Funeral Service Licensee

▶

22. Name and Address of Facility

Schoenberg Memorial Chapel  
519 Philadelphia Pike, Wilmington, DE 19809

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CAD  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NOT KNOWN

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶

29c. License number

D3605X

29d. Date signed (Month, Day, Year)

3/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICIA SWANAHAN M.D. 120 SPEER RD CHESTERTOWN MD

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

▶

21620

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

671VA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12415

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Andrew Jackson Sutton

2. Date of Death

Month  
MarchDay  
27Year  
1999

3. Time of Death

7:49AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

243-16-1743

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 12, 1921

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2111 Hannon Street

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: African

American

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

D.C. Public Schools

17. Father's Name (First, Middle, Last)

Peter Sutton

18. Mother's Name (First, Middle, Maiden Surname)

Libby Jones

19a. Informant's Name/Relationship (Type, Print)

Lina Mae Strong Sutton - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2111 Hannon St., Hyattsville, Maryland 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Quantico National Cem.

Date

4/2/99

20c. Location - City or Town, State

Triangle, VA

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. CARCINOMA OF LUNGS

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

FEW MONTHS

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending  
investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Al Jawad Waqas M.D.

29c. License number

D0052931

29d. Date signed (Month, Day, Year)

3/27/99 27th MARCH, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AL JAWAD WAQAS 11119 ROCKVILLE PIKE, SUITE 100, ROCKVILLE MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

Benjamin S. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12416

|   |   |                           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
|---|---|---------------------------|--|--|--|---|--|--|--|---|---|-----------------|----------------------------------|--|------------------------|-----------------|----------------------------------|--|----|--|--|----------------------------------|--|--|----|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Arthur F. Slade</b>                                      |                           |  |  |  | 2. Date of Death<br>Month Day Year<br><b>March 24, 1999</b>                   |  |  | 3. Time of Death<br><b>12:25 PM</b>                                |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>VA Maryland Health Care System</b> |                           |  |  |  | 4b. City, Town, or Location of Death<br><b>Perry Point</b>                    |  |  | 4c. County of Death<br><b>Cecil</b>                                |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>224-36-1257</b>   |                           | 6. Sex<br><b>1 M 2 F</b>   |  | 7. Age (in yrs. last birthday)<br><b>69</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>12/24/29</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Charlotte, N.C.</b> |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   | Usual Residence of Decedent   |                           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 10a. State<br><b>D.C.</b>   |   | 10b. County<br><b>N/A</b> |  | 10c. City, Town or Location<br><b>Washington</b> |  |   |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 10e. Street and Number<br><b>1221 S St., N.W.</b>   |   |                           |  |  | 10f. Zip Code<br><b>20009</b>  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 No</b> |  |  | 14. Race - American Indian, Black, White, etc.<br><b>Black</b>     |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>  |   |                           |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Taxi Driver</b>  |   |  | 16b. Kind of Business/Industry<br><b>Livery</b>  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Perry Slade</b>   |   |                           |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Tabon</b>  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Hazel J. Slade/Wife</b>  |   |                           |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as # 10 above</b>       |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Quantico Nat'l. Cem.</b>  |  |  | Date<br><b>3/30/99</b>  |  | 20c. Location - City or Town, State<br><b>Triangle, Va.</b>                                      |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |                           |  |  | 22. Name and Address of Facility<br><b>H.S. Washington &amp; Sons Co., Inc.<br/>4925 Burroughs Ave., N.E., Wash., D.C. 20019</b> |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |                           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| <table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last             </td> <td>a. <b>Massive Recurrent Cerebral Vascular Accidents</b></td> <td><b>3 Months</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Hypertension</b></td> <td><b>10 Years</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">c.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">d.</td> <td></td> </tr> </table> |   |                           |  |  |  |   |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <b>Massive Recurrent Cerebral Vascular Accidents</b> | <b>3 Months</b> | Due to (or as a consequence of): |  | b. <b>Hypertension</b> | <b>10 Years</b> | Due to (or as a consequence of): |  | c. |  |  | Due to (or as a consequence of): |  |  | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a. <b>Massive Recurrent Cerebral Vascular Accidents</b>   | <b>3 Months</b>           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   | Due to (or as a consequence of):  |                           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   | b. <b>Hypertension</b>  | <b>10 Years</b>           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   | Due to (or as a consequence of):  |                           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| c.  |   |                           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| Due to (or as a consequence of):  |   |                           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| d.  |   |                           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |   |                           |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   |   |                           |  |  |  |   |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   |   |                           |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |   |                           | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |   |                           | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><b>1 Yes 2 No</b>              |  | 28d. Describe how injury occurred                                  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
|   |   |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                     |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>  |   |                           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 29b. Signature and Title of certifier<br><i>[Signature]</i>   |   |                           |  |  | 29c. License number<br><b>D30951</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>3-24-99</b>  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANGELO LUCCO, M.D., VA Maryland Health Care System, Perry Point, Maryland 21902</b>  |   |                           |  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |   |                           | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |  |  |   |   |                 |                                  |  |                        |                 |                                  |  |    |  |  |                                  |  |  |    |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME KNOWN TO PHYSICIAN:

ARTHUR FLETCHER SLADE  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

1933 5 3

|  |  |   |  |   |   |   |  |  |
|--|--|---|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>CARLIS SPEARS                            |   |  |   | 2. Date of Death<br>Month: APRIL Day: 03 Year: 1999 |   | 3. Time of Death<br>2055                             |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>510 LONGWOOD DRIVE |   |  |   | 4b. City, Town, or Location of Death<br>ROCKVILLE   |   | 4c. County of Death<br>MONTGOMERY                    |  |
| Funeral<br>Director  | 5. Social Security Number<br>577-90-7435   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>33 Yrs.           |   | 8. Date of Birth (Month, Day, Year)<br>Nov. 29, 1965 |  |
|  | 9. Birthplace (State or Foreign Country)<br>Wash. D.C.                               |   | 10a. State<br>Md.  |   | 10b. County<br>Montgomery                           |   | 10c. City, Town or Location<br>Silver Spring         |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>1110 Fidler Lane #415   |  | 10f. Zip Code<br>20910  |   | 10g. Citizen of What Country?<br>U.S.A.   |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Custodial Worker                         |  | 16b. Kind of Business/Industry<br>Private   |   | 17. Father's Name (First, Middle, Last)<br>Unknown  |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br>Unknown   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Becky Dunlap/Caretaker  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6200 2nd St., N.W. Wash. D.C. 20011  |   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Forest Hills Cemetery  |  | 20c. Location - City or Town, State<br>Clinton, Md.   |  | 21. Signature of Funeral Service Licensee<br><i>Becky Dunlap</i>  |   | 22. Name and Address of Facility<br>Johnson & Jenkins Inc.<br>716 Kennedy St., N.W. Wash. D.C. 20011  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. SEIZURE DISORDER<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |   |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |   |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>MENTAL RETARDATION   |  |   |  |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |   |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Friend's Residence   |  |   |  |   |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  |   |   |   |  |  |
| 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Dennis J. Chute</i>  |  |   |  |   |   |   |  |  |
| 29c. License number<br>O.C.M.E   |  |   |  |   |   |   |  |  |
| 29d. Date signed (Month, Day, Year)<br>APRIL 04, 1999  |  |   |  |   |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 07 1999   |  |   |  |   |   |   |  |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |  |   |   |   |  |  |







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12418

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |  |  |
|--|---|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ella S. Stephens</b>                               |   |  |   | 2. Date of Death<br>Month Day Year<br><b>March 28 1999</b>   |  | 3. Time of Death<br><b>6:30 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Springbrook Nursing Home</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b> |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-05-7669</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>81</b> Yrs.  | If Under 1 Year<br>Months Days                               | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Mar 22 1918</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Wash. DC.</b>   |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince Georges</b>  |  | 10c. City, Town or Location<br><b>College Park</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>5813 Bryn Mawr Rd.</b>  |   |   |  | 10f. Zip Code<br><b>20740</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  |  | 16b. Kind of Business/Industry<br><b>Gov't.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Elmer Lord</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Abbie Brown</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>George Stephens, Son</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 237, Avenue, Md. 20609</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>   |  | Date<br><b>4/2/99</b>  |  | 20c. Location - City or Town, State<br><b>Brentwood, Md.</b>   |
| 21. Signature of Funeral Service Licensee<br><i>George L. Lord</i>   |   |   |  | 22. Name and Address of Facility<br><b>Ft. Lincoln F.H.<br/>3401 Bladensburg Rd. Brentwood, Md. 20722</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Pneumonia, post-obstructive</b><br>Due to (or as a consequence of):<br>b. <b>Colon Cancer, Metastatic to Lung</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>3 wks</b><br><b>Many yrs</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation, Depression</b>   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br><i>Stuart J. Turkewitz MD</i>  |  | 29c. License number<br><b>D31001</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/30/99</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Stuart J. Turkewitz, M.D.</b>   |   |   |  | 7500 Greenway Ctr. Dr. #430<br>Greenbelt, MD 20770  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>  |   | 32. Registrar's Signature<br><i>James A. Smith</i>  |  |   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

*[Handwritten signature]*

MAR 2 1983

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12419

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VICTORINE C. SULLIVAN

2. Date of Death

Month Day Year  
MARCH 28, 1999

3. Time of Death

1601

4a. Facility Name (If not institution, give street and number)

3251 CHESTERGROVE ROAD

4b. City, Town, or Location of Death

FORESTVILLE

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

577-42-1173

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 27, 1930

9. Birthplace (State or Foreign Country)

WASHINGTON DC

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3251 CHESTER GROVE RD

10f. Zip Code

20772

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CIRCULATION SUP.

16b. Kind of Business/Industry

WASHINGTON POST

17. Father's Name (First, Middle, Last)

JOHN BOND

18. Mother's Name (First, Middle, Maiden Surname)

PEARL BROWN

19a. Informant's Name/Relationship (Type, Print)

THERESA GOVAN/ NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9900 GEORGIA AVE, SILVER SPRING, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. OLIVET CEMETERY

Date

4-5-99

20c. Location - City or Town, State

WASHINGTON DC

21. Signature of Funeral Service Licensee

Cora J. McKell

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME  
5538 MARLBORO PIKE FORESTVILLE, MD 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MARIO F. GOLIE JR MD

29c. License number

D33954

29d. Date signed (Month, Day, Year)

MARCH 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

S. S. S.

State  
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE UNIVERSITY OF CHICAGO  
DEPARTMENT OF CHEMISTRY  
JANUARY 1950

TO THE HONORABLE CHAIRMAN  
OF THE BOARD OF TRUSTEES  
OF THE UNIVERSITY OF CHICAGO  
FROM  
THE DEPARTMENT OF CHEMISTRY  
SUBJECT: A REPORT ON THE  
PROGRESS OF THE RESEARCH  
DURING THE YEAR 1949  
BY  
J. H. COOPER  
AND  
J. E. HOLT

The following is a summary of the work done in the Department of Chemistry during the year 1949. The work was carried out under the direction of the Department Chairman, J. H. COOPER, and the Department Secretary, J. E. HOLT. The work was carried out in the Department of Chemistry, University of Chicago, Chicago, Illinois.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12420

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stephen Ross Smith, Sr.

2. Date of Death

March 26 1999

3. Time of Death

4:35 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

246-24-3298

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 2, 1925

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7511 Sweetbriar Drive

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: KOREAN

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

President &amp; Treasurer

16b. Kind of Business/Industry

Heating and Air  
Conditioning Company

17. Father's Name (First, Middle, Last)

Raynor Smith

18. Mother's Name (First, Middle, Maiden Surname)

Betty Elizabeth Tatum

19a. Informant's Name/Relationship (Type, Print)

Nancy G. Smith - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7511 Sweetbriar Drive, College Park, Maryland 20740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

03/30/99

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gasch's Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d. PNEUMONIA

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION  
GASTROINTESTINAL BLEEDING  
RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Piece of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D 20757

29d. Date signed (Month, Day, Year)

3/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Anoop S. Rao / 800 Good Luck Rd (302) LANHAM MD

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020  
Dr. Stephen Ross Smith, Sr.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12421

Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
|---|---|---|--|--|--|--|--|--|---|---------------------------------|--|--|--------------------------|--------------|-------------------------------|--------------|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Marye Ruth Stupalsky</b>   |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>27</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>9:43pm</b>  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Doctors Community Hospital</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>  |  | 4c. County of Death<br><b>Prince George's Co.</b>  |  |   |                                 |  |  |                          |              |                               |              |    |
| Funeral<br>Director   | 5. Social Security Number<br><b>233-20-2321</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   | If Under 1 Year<br>Months Days           | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>March 29, 1919</b>                                   |  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b> |   |                                 |  |  |                          |              |                               |              |    |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Prince Georges'</b>   | 10c. City, Town or Location<br><b>Greenbelt</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | 10e. Street and Number<br><b>21 N Ridge Road</b>  |   |  | 10f. Zip Code<br><b>20770</b>            |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:          |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Collage (1-4or 5+)</b><br><b>Secretary</b> |  | 16b. Kind of Business/Industry<br><b>Home Builders Assoc.</b>  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Gartin</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Genevra Maude Johnson</b>  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Coutts-Niece</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>107 James Bray, Williamsburg, Virginia 23188</b>   |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>   |  | Data<br><b>3-30-99</b>   |  | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | 21. Signature of Funeral Service Licensee<br><i>John S. Johnson</i>   |   |  |  | 22. Name and Address of Facility<br><b>Fort Lincoln Funeral Home</b><br><b>3401 Bladensburg Rd., Brentwood, Maryland 20722</b>   |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Myocardial Infarction</b></td> <td>Approximate Interval Between Onset and Death<br/><b>WEEKS</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. <b>Cardiac Arrest</b></td> <td><b>WEEKS</b></td> </tr> <tr> <td>c. <b>Bilateral Pneumonia</b></td> <td><b>WEEKS</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |  |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Myocardial Infarction</b> | Approximate Interval Between Onset and Death<br><b>WEEKS</b> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. <b>Cardiac Arrest</b> | <b>WEEKS</b> | c. <b>Bilateral Pneumonia</b> | <b>WEEKS</b> | d. |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Myocardial Infarction</b>   | Approximate Interval Between Onset and Death<br><b>WEEKS</b>  |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | b. <b>Cardiac Arrest</b>  | <b>WEEKS</b>  |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | c. <b>Bilateral Pneumonia</b>   | <b>WEEKS</b>  |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | d.  |   |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypotension</b><br><b>Hypoxia</b>  |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |                                 |  |  |                          |              |                               |              |    |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>          |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                                |   |                                 |  |  |                          |              |                               |              |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Dr. Elwood Holland</i>  |  | 29c. License number<br><b>D20989-MA.</b> |  | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>  |  |  |   |                                 |  |  |                          |              |                               |              |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6005 LAUDOVER RD STE 3 CHEVERLY, MD. 20785</b>   |   |   |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |
| 31. Date filed (Month, Day, Year)<br><b>MAR 30 1999</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |  |   |                                 |  |  |                          |              |                               |              |    |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12422

|  |  |  |   |   |  |                                 |  |   |  |  |  |  |
|--|--|--|---|---|--|---------------------------------|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedant's Name (First, Middle, Last)<br><b>JESSIE V. STRADER</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 1, 1999</b>   |                                 |  |   | 3. Time of Death<br><b>6:00 AM</b>   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Millennium Nursing Home</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie, MD</b>   |                                 |  |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>198-18-7077</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>Jun 22, 1919</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Connesville, PA</b>                             |  |  |  |
|  | Usual Residence of Decedant  |  |   |   |  |                                 |  |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10e. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince Georges</b>  |   | 10c. City, Town or Location<br><b>Clinton</b>  |                                 |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
|  | 10e. Street and Number<br><b>9201 Cheltenham Avenue</b>  |  |   |   | 10f. Zip Code<br><b>20735</b>  |                                 |  |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedant Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |  |   | 14. Race - American Indian, Black, White, etc.<br><b>Specify Black</b>                         |  |  |  |
|  | 15. Decedant's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)  |  |   |   | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steel Worker</b>   |                                 |  |   | 16b. Kind of Business/Industry<br><b>Manufacturing</b>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>James Strader</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Annie Graves</b>  |                                 |  |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard Strader / Son</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9201 Cheltenham Avenue, Clinton, MD 20735</b>  |                                 |  |   |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Penn-Lincoln Cemetery</b>   |                                 | Data<br><b>4/5/99</b>                                      |   | 20c. Location - City or Town, State<br><b>McKeesport, PA</b>                                   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Larry L. Simmons</i>   |  |   |   | 22. Name and Address of Facility<br><b>Pope Funeral Home, 5538 Marlboro Pike, Forestville, MD 20747</b>  |                                 |  |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; align-items: flex-start;"> <div style="margin-right: 10px;">                     Immediate Cause (Final disease or condition resulting in death)<br/><br/>                     Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                 </div> <div>                     a. <b>ACUTE PULMONARY EDEMA</b><br/>                     Due to (or as a consequence of):<br/>                     b. <b>END STAGE RENAL DISEASE</b><br/>                     Due to (or as a consequence of):<br/>                     c. <b>CHRONIC RENAL FAILURE</b><br/>                     Due to (or as a consequence of):<br/>                     d.                 </div> </div> |  |   |   |  |                                 |  |   |  |  | Approximate Interval Between Onset and Death   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MULTIPLE CEREBROVASCULAR ACCIDENTS,<br/>DIABETES MELLITUS, PERIPHERAL VASCULAR DISEASE, RECURRENT MYOCARDIAL INFARCTIONS</b>  |  |   |   |  |                                 |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |  |   |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                    |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   | 29b. Signature and title of certifier<br><i>R. Rangarajau</i>   |  |                                 |  | 29c. License number<br><b>D0057288</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/2/99</b> |  |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Ramaswamy Rangarajau, MD 7445-A Furnace Branch Road, Glen Burnie, MD 21060</b>  |  |  |   |   |  |                                 |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 02 1999</b>  |  |  |   | 32. Registrar's Signature<br><i>B. [Signature]</i>  |  |                                 |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12423

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Lee Strausburg

2. Date of Death

March 31, 1999

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

220-01-7120

6. Sex

M 20 F

7. Age (in yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 19, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1102 Mill Creek Road

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates: 1940-4113. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
Twelve Years

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Bethlehem Steel  
Baltimore, Maryland

17. Father's Name (First, Middle, Last)

Charles Roscoe Strausburg

18. Mother's Name (First, Middle, Maiden Surname)

Nettie May Cartridge

19a. Informant's Name/Relationship (Type, Print)

Ellen L. Strausburg (sister-in-law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1102 Mill Creek Road, Fallston, Maryland 21047

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Slate Ridge Cemetery

Date

4/5/99

20c. Location - City or Town, State

Delta, Pennsylvania

21. Signature of Funeral Service Licensee

Thomas M. Patterson, Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home  
Perryville, Maryland 21903-018823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Bilateral Pneumonia

Due to (or as a consequence of):

One Week

b. Acute Renal Failure

Due to (or as a consequence of):

One Week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?  
1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
investigation  
2 Accident 6 Could not be  
determined  
3 Suicide  
4 Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

V. K. Nellore

29c. License number

D21779

29d. Date signed (Month, Day, Year)

March 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIJAY NELLORE, M.D., VA Maryland Health Care System, Perry Point, MD 21902

31. Date filed (Month, Day, Year)

APR 02 1999

32. Registrar's Signature

B. Sparks

State  
RegistrarNAME KNOWN TO PHYSICIAN:  
EDWARD LEE STRAUSBURG  
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12424

|  |   |                                       |   |  |  |  |   |  |  |  |
|--|---|---------------------------------------|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Olga Smolnikow  |                                       |   |  | 2. Date of Death<br>Month Day Year<br>March 31, 1999   |  |   |  | 3. Time of Death<br>0100                               |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Sunrise Care and Rehabilitation |                                       |   |  | 4b. City, Town, or Location of Death<br>Elkton   |  |   |  | 4c. County of Death<br>Cecil                           |  |
| Funeral<br>Director  | 5. Social Security Number<br>135-30-0801  |                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>94 Yrs.  |  | 8. Data of Birth (Month, Day, Year)<br>May 22, 1904 |  | 9. Birthplace (State or Foreign Country)<br>Yugoslavia |  |
|  | Usual Residence of Decedent   |                                       |   |  |  |  |   |  |  |  |
| 10a. State<br>New Jersey   |   | 10b. County<br>Bergen                 |   | 10c. City, Town or Location<br>Mahwah  |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br>118 Ramapo Valley Road   |   |                                       |   | 10f. Zip Code<br>07430   |  |  |   | 10g. Citizen of What Country?<br>United States   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collega (1-4or 5+)<br>UNKNOWN   |   |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Food Service                    |  |  |   | 16b. Kind of Business/Industry<br>Ford Plant   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Anton Velenovic   |   |                                       |   |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Spacena                           |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mary A. Broughton/ Daughter  |   |                                       |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>137 Sylmar Road, Rising Sun, Maryland 21911 |  |  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                                       |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Novo-Diveevo Russian Orthodox Church                               |  | Data<br>April 2, 1999  |   | 20c. Location - City or Town, State<br>Spring Valley, New York                                     |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |                                       |   | 22. Name and Address of Facility<br>Hicks Home for Funerals, P.A.<br>103 West Stockton Street, Elkton, Maryland 21921                        |  |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |                                       |   |  |  |  |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <u>cerebrovascular accident</u><br>Due to (or as a consequence of):<br>b. <u>hypertension</u><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____  |   |                                       |   |  |  |  |   |  |  |  |
| Approximate Interval Between Onset and Death<br>41 days  |   |                                       |   |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                       |   |  |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |                                       |   |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                       |   |  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |                                       |   |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                       |   |  |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |   |                                       |   |  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                                       |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                                       |   |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |                                       |   | 29c. License number<br>035779  |  |  |   | 29d. Date signed (Month, Day, Year)<br>March 31st, 1999  |  |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>W. Bruce Obenshain, MD   |   |                                       |   | 251 S. Bohemia Ave<br>Cecilton, Md. 21913  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999   |   |                                       |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

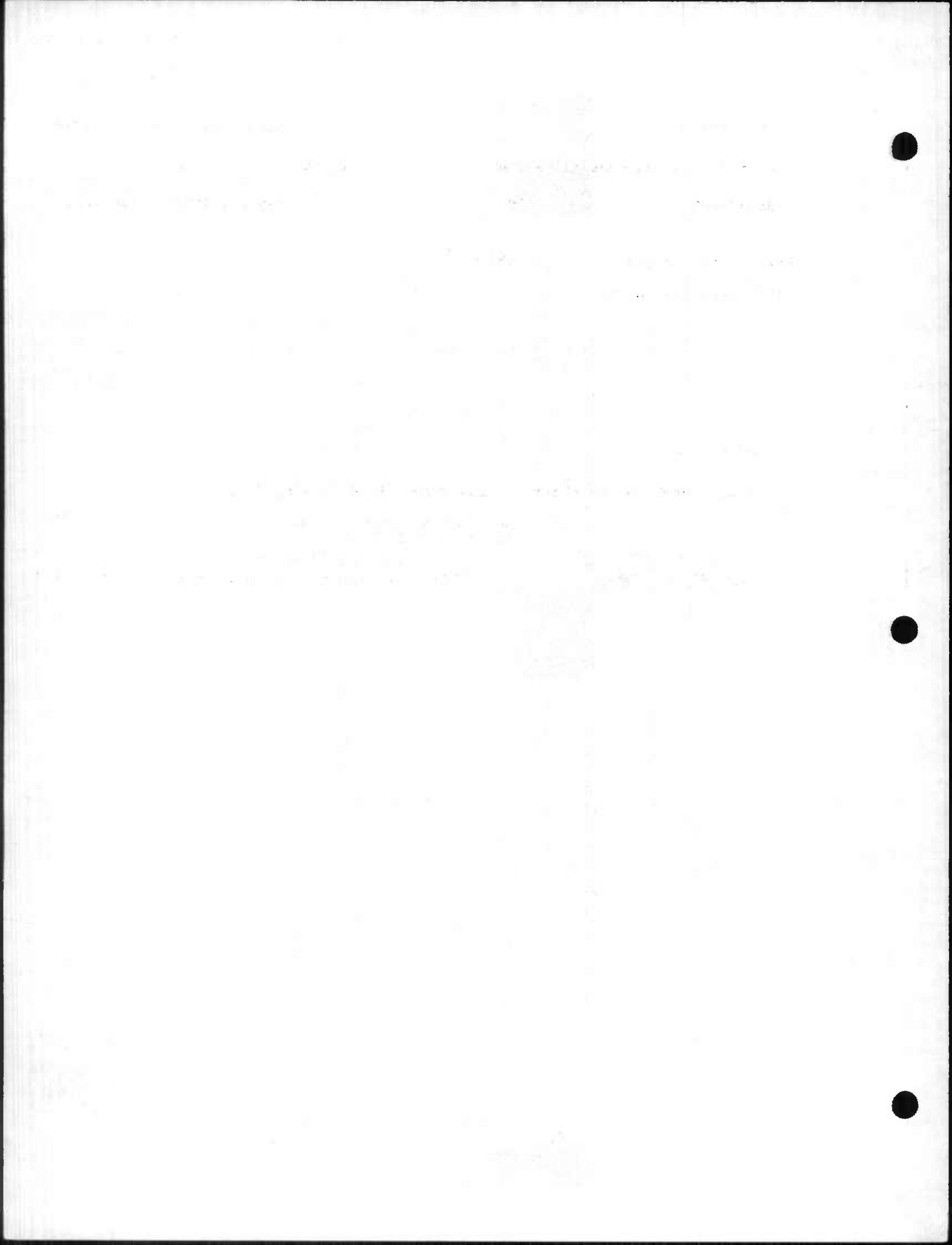
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12425

|   |  |   |   |   |  |  |   |  |
|---|--|---|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>HELEN JANE STAUB</b>  |   |   |   | 2. Date of Death<br>Month <b>3</b> Day <b>26</b> Year <b>99</b>  |  | 3. Time of Death<br><b>2:47pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>FAIRHAVEN</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>SYKESVILLE</b>  |  | 4c. County of Death<br><b>CARROLL</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>152-44-6517</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 27 1917</b>   | 9. Birthplace (State or Foreign Country)<br><b>NJ</b>        |
|   | Usual Residence of Decedent  |   |   |   |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md</b>  | 10b. County<br><b>Carroll</b>   |   | 10c. City, Town or Location<br><b>Sykesville</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |  |
|   | 10e. Street and Number<br><b>7200 Third Ave A-8C</b>   |   |   |   | 10f. Zip Code<br><b>21784</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                               |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>2</b>  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>medical assistant</b> |  |  | 16b. Kind of Business/Industry<br><b>health care</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Henry H. Fryling</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Ohl</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert J. Staub (son)</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1002 Cockeys Mill Rd., Reisterstown, MD 21136</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                    |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation Serv.</b>  |   | Date<br><b>3-29-99</b>   |  | 20c. Location - City or Town, State<br><b>Hampstead, MD</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Brian D. Haight</b>  |   |   |   | 22. Name and Address of Facility<br><b>Haight Funeral Home &amp; Chapel<br/>P.O. Box 195 Sykesville, Md. 21784</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Lung Carcinoma with liver metastases</b> |   |   |   |  |  |   | Approximate Interval Between Onset and Death<br><b>Years</b> |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |  |  |   |  |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Paroxysmal Atrial Fibrillation</b>  |  |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred                            |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Ernestine Wright, MD</b>  |   | 29c. License number<br><b>D52740</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/26/99</b>                            |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ERNESTINE WRIGHT, FAIRHAVEN 7200 THIRD AVENUE, SYKESVILLE 21784</b>  |  |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |   |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12426

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Estella Smith

2. Date of Death

Month Day Year  
MARCH 28 1999

3. Time of Death

2:05 Am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CARROLL COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

Carroll

5. Social Security Number

213-24-8771

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 23, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Union Bridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

210 Bucher John Rd.

10f. Zip Code

21791

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

cook/kitchen worker

16b. Kind of Business/Industry

service center

17. Father's Name (First, Middle, Last)

Harvey Vernon Whitmore

18. Mother's Name (First, Middle, Maiden Surname)

Mary Catherine Shryock

19a. Informant's Name/Relationship (Type, Print)

Carroll E. Smith - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

210 Bucher John Rd., Union Bridge, MD 21791

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Pipe Creek Cemetery

Date

3/30/99

20c. Location - City or Town, State

near Linwood, MD

21. Signature of Funeral Service Licensee

Catherine D. Shryock

22. Name and Address of Facility

Hartzler Funeral Home  
310 Church St., New Windsor, MD 2177623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Lymphoma  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D51596

29d. Date signed (Month, Day, Year)

MARCH 28 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. AMBALAVANAR, CARROLL COUNTY GENERAL HOSPITAL, 200 MEMORIAL AVE, WESTMINSTER, MD 21157

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12427

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred L. Sayers

2. Date of Death  
Month Day Year

March 27 1999

3. Time of Death

1:12 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1852 Snydersburg Rd

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

234-62-4223

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

July 15, 1939

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1852 Snydersburg Rd

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Files Assistant

16b. Kind of Business/Industry

Social Security

17. Father's Name (First, Middle, Last)

Luther W. Durst

18. Mother's Name (First, Middle, Maiden Surname)

Susanna Aronhalt

19a. Informant's Name/Relationship (Type, Print)

Jack L. Sayers Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1852 Snydersburg Rd. Westminster MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Memorial Gardens 3/30/99 Finksburg, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J K As...

22. Name and Address of Facility

Pitts Funeral Home & Chapel, P.A.  
412 Washington Rd Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Flavio Kruter MD

29c. License number

D35392

29d. Date signed (Month, Day, Year)

3/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Flavio Kruter 224 Washington Hts Westminster, MD 21157

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

Deneva G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12428

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Woodrow Segafosse

2. Date of Death

March 28 1999

3. Time of Death

5:53 A

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

215-07-2878

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 17, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2201 Old Westminster Pike Tr. 26

10f. Zip Code

21048

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Egg Dealer

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

William G Segafosse

18. Mother's Name (First, Middle, Maiden Surname)

Ida Pearl McAllister

19a. Informant's Name/Relationship (Type, Print)

Frances B. Segafosse (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2201 Old Westminster Pike Tr. 26 Finksburg MD 21048

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Uniontown Methodist Cemetery 3/29/99 Uniontown, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John K. A. [Signature]

22. Name and Address of Facility

Pitts Funeral Home + Chapel, P.A.  
412 Washington RD Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Carcinoma with Complications  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

in specimen  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King [Signature]

29c. License number

OCME

29d. Date signed (Month, Day, Year)

March 29 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. King 111 Penn St Baltimore MD 21201

31. Date filed (Month, Day, Year)

MAR 29 1999

32. Registrar's Signature

[Signature] G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12429

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Ella Smith

2. Date of Death

March 30 1999

3. Time of Death

3:15pm

4a. Facility Name (If not Institution, give street and number)

Westminster Nursing &amp; Convalescent Center

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

214-34-3912

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Sept 14 1935

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Md

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

203 S. Court Street

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

nurse

16b. Kind of Business/Industry

health care

17. Father's Name (First, Middle, Last)

Charles W. Smith Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Frances Gertrude Brothers

19a. Informant's Name/Relationship (Type, Print)

Michael W. T. Smith (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

203 S. Court St., Westminster, MD 21157

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Carroll Cremation

Date

4-3-99

20c. Location - City or Town, State

Hampstead MD

21. Signature of Funeral Service Licensee

► Paige Haight Herbert

22. Name and Address of Facility

Haight Funeral Home &amp; Chapel

P.O. Box 195 Sykesville, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. cirrhosis of liver

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease  
Non Insulin dependent Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

D0051705

29d. Date signed (Month, Day, Year)

03. 30. 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

419 F. Malcolm Dr. Westminster, MD. 21157

Dr. Maganbhai Pansuriya MD

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

► [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



DOCTOR

DR. J. H. HARRIS, JR.

1911-12-14



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12430

|  |  |   |   |                                       |  |   |   |  |  |
|--|--|---|---|---------------------------------------|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Kenneth Van Doren</b>   |   |   |                                       | 2. Date of Death<br>Month <b>3</b> Day <b>25</b> Year <b>99</b>  |   | 3. Time of Death<br><b>10:52p.m.</b>  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>9056 Hardesty Dr.</b>   |   |   |                                       | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |   | 4c. County of Death<br><b>P.G.</b>  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>148-32-7498</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>1/22/42</b>   |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>N.J.</b>  |   | 10a. State<br><b>MD</b>   |                                       | 10b. County<br><b>P.G.</b>   |   | 10c. City, Town or Location<br><b>Clinton</b>   |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   |   |                                       | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |
|  | 10e. Street and Number<br><b>9056 Hardesty Dr.</b>   |   |   |                                       | 10f. Zip Code<br><b>20735</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |   | College (1-4or 5+)  |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>   |   | 16b. Kind of Business/Industry<br><b>Private</b>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Van Doren</b>   |   |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Richardson</b>  |   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Pamela T. Van Doren</b>   |   |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9056 Hardesty Dr. Clinton, Md. 20735</b>   |   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cem.</b>  |                                       | Date<br><b>3/31/99</b>   |   | 20c. Location - City or Town, State<br><b>Clinton, Md.</b>  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Janice Edwards</i>   |   |   |                                       | 22. Name and Address of Facility<br><b>Hodges and Edwards<br/>3910 Silver Hill RD. Suitland, Md. 20746</b>   |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. metastatic lung cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |                                       |  |   |   | Approximate Interval Between Onset and Death<br><b>2 yrs</b>   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |                                       |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |                                       |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                       |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of Certifier<br><i>D.J. Hawdak MD</i>  |   | 29c. License number<br><b>D-17605</b> |  | 29d. Date signed (Month, Day, Year)<br><b>3/28/99</b>                                       |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>8926 Woodyard Rd. Suite 201 Clinton, MD</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>D.J. HAWDAK MD</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |   |                                       |  |   |   |  |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |   |                                       |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12431

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE AFRA VANSANT

2. Date of Death

Month  
MARCHDay  
29,Year  
1999

3. Time of Death

04:10 PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral  
Director

5. Social Security Number

185-28-5903

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
03-05-1935

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Delaware

10b. County

New Castle

10c. City, Town or Location

Newark

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

114 Iroquois Court

10f. Zip Code

19702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Inspection clerk

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

Wilburn Lollar

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Danial

19a. Informant's Name/Relationship (Type, Print)

Leonard H. Duck / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 Iroquois Court, Newark, DE 19702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gracelawn Memorial Park

Date

4/2/1999

20c. Location - City or Town, State

New Castle, DE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Beeson Memorial Services

2053 Pulaski Hwy., Newark, DE 19702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

3 MONTHS

c. MUCOUS PLUGGING

Due to (or as a consequence of):

3 WEEKS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STROKE, HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings

available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending2 ☐ Accident investigation3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Krystn R. Wagner, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MARCH 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krystn R. Wagner, M. D., JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. 21287

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

B. Adams

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

99 12432

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Curtis Nathaniel Wider

2. Date of Death  
Month Day Year  
MARCH 23, 1999

3. Time of Death  
1:20 PM.

4a. Facility Name (If not institution, give street and number)

RUSSELL AVE. AND KAYWOOD DR.

4b. City, Town, or Location of Death

MT. RAINIER

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

577-15-6843

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

23 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 3, 1976

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Mt. Rainier

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4200 Kaywood Drive

10f. Zip Code

20721

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Orlester Wider

18. Mother's Name (First, Middle, Maiden Surname)

Jacqueline Jackson

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Wider - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4200 Kaywood Drive, Mt. Rainier, MD 20721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Shiloh Baptist Church Cem 3-30-99 Woodville, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Julia Marshall*

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N.W. Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Gunshot Wound of Head*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☒ Other (Specify)

AT

SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☒ Homicide

28a. Date of Injury

(Month, Day, Year)

3/23/99

28b. Time of Injury

13091H

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Russell Avenue & Kaywood Drive Mount Rainier Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician

2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Theodore M. King*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*THEODORE M. KING*

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 31 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2101 1 0 624



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12433

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Benjamin Washick

2. Date of Death

Month Day Year  
March 22, 1999

3. Time of Death

9:00pm

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's Co.

Funeral  
Director

5. Social Security Number

207-07-0966

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 7, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7140 Presley Road

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Joseph Washick

18. Mother's Name (First, Middle, Maiden Surname)

Victoria Goj

19a. Informant's Name/Relationship (Type, Print)

Louise Fawbush - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7140 Presley Road, Lanham, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate Of Heaven Cemetery

Date

03/25/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

*B. Goj*

22. Name and Address of Facility

Gasch's Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RENAL FAILURE

Due to (or as a consequence of):

1 YEAR

c. MICK PINKS SYNDROME

Due to (or as a consequence of):

1 WEEK

d. DIABETES MELLITUS

15 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

15820

29d. Date signed (Month, Day, Year)

3/23/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HONG LEE and 3415 Hamilton St Hyattsville MD 20782

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Washick

Benjamin





Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

12434

|  |  |  |   |   |  |                          |  |  |  |  |  |
|--|--|--|---|---|--|--------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>BERNICE WILLIAMS                                 |  |   |   | 2. Date of Death<br>Month Day Year<br>MARCH 25, 1999   |                          |  |  | 3. Time of Death<br>9:10pm   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>SOUTHERN MARYLAND HOSPITAL |  |   |   | 4b. City, Town, or Location of Death<br>CLINTON  |                          |  |  | 4c. County of Death<br>PRINCE GEORGES  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>577-22-4866   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>76 Yrs.  |                          | 8. Date of Birth (Month, Day, Year)<br>DEC. 28, 1922 |  | 9. Birthplace (State or Foreign Country)<br>WASHINGTON DC  |  |  |
|  | Usual Residence of Decedent  |  |   |   | 10a. State<br>10b. County<br>10c. City, Town or Location<br>WASHINGTON DC  |                          |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br>1460 CONGRESS PL S.E.  |  |  |   | 10f. Zip Code<br>20020  |  |                          |  | 10g. Citizen of What Country?<br>UNITED STATES                                       |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                          |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                                 |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>MEDICAL CLERK  |  |                          |  | 16b. Kind of Business/Industry<br>GOVT.  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>WILLIAM MCKINNEY  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>CLARA BELL MONDOWNEY   |  |                          |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>JOAN TYLER-BRADLEY / DAUGHTER  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2423 MONROE ST. N.E. WASHINGTON DC 20018   |  |                          |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MARYLAND NATIONAL PARK  |   |  | Date<br>3-31-99          |  | 20c. Location - City or Town, State<br>LAUREL, MD                                    |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Alexander S. Pope</i>  |  |  |   | 22. Name and Address of Facility<br>ALEXANDER S. POPE FUNERAL HOME<br>2617 PENN.AVE S.E. WASHINGTON DC 20020  |  |                          |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. LUNG CARCINOMA (METASTATIC)<br>Due to (or as a consequence of):<br>b. COLON CARCINOMA<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |  |   |   |  |                          |  |  |  | Approximate Interval Between Onset and Death<br>1 1/2 YEARS<br>15 YEARS  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |                          |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |  |  |   |   |  |                          |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |  |   |   |  |                          |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
|  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                    |  |  |   |   |  |                          |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Rita Gupta MD</i>  |  |  |   | 29c. License number<br>D43346   |  |                          |  | 29d. Date signed (Month, Day, Year)<br>3/26/99                                       |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>RITA GUPTA MD, 8926 WOODYARD ROAD #201, CLINTON, MD 20735  |  |  |   |   |  |                          |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 30 1999   |  |  |   | 32. Registrar's Signature<br><i>B. Spade</i>  |  |                          |  |  |  |  |  |

3 1/2

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12435

|   |  |   |  |   |   |  |  |   |
|---|--|---|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mariah J. Williams</b>                    |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>27</b> Year <b>1999</b> |  | 3. Time of Death<br><b>4:25 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Woodside Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>          |  | 4c. County of Death<br><b>Montgomery</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-24-2604</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 21, 1924</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Augusta, GA.</b>                             |
|   | Usual Residence of Decedent  |   |  |   |   |  |  |   |
| 10e. State<br><b>MD</b>   |  | 10b. County<br><b>Prince Georges</b>  |  | 10c. City, Town or Location<br><b>New Carrollton</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>5713 83rd Place</b>  |  |   |  | 10f. Zip Code<br><b>20784</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> Collega (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accounting Tech.</b>  |   |  | 16b. Kind of Business/Industry<br><b>Dept. of Navy</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Preston T. Johnson</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Loe</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia Johnson</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5713 83rd Place<br/>New Carrollton, Md. 20784</b>   |   |  |  |   |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery 4-5-99</b>   |   |  | 20c. Location - City or Town, State<br><b>Silver Spring, MD.</b>                               |   |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th St. NW Washington, DC 20011</b>   |   |  |  |   |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cancer of the esophagus with Metastasis</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>1996</b>                                 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |  |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   |  |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28d. Describe how injury occurred  |   |
|   |  |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. Signature and title of certifier<br>  |   |  |  | 29c. License number<br><b>MD25214</b>   |
|   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>3-30-99</b>   |   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Gilbert Hurwitz 1800 Eye St NW Suite 602 Washington, DC</b>  |  |   |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1999</b>   |  |   |  | 32. Registrar's Signature<br>  |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

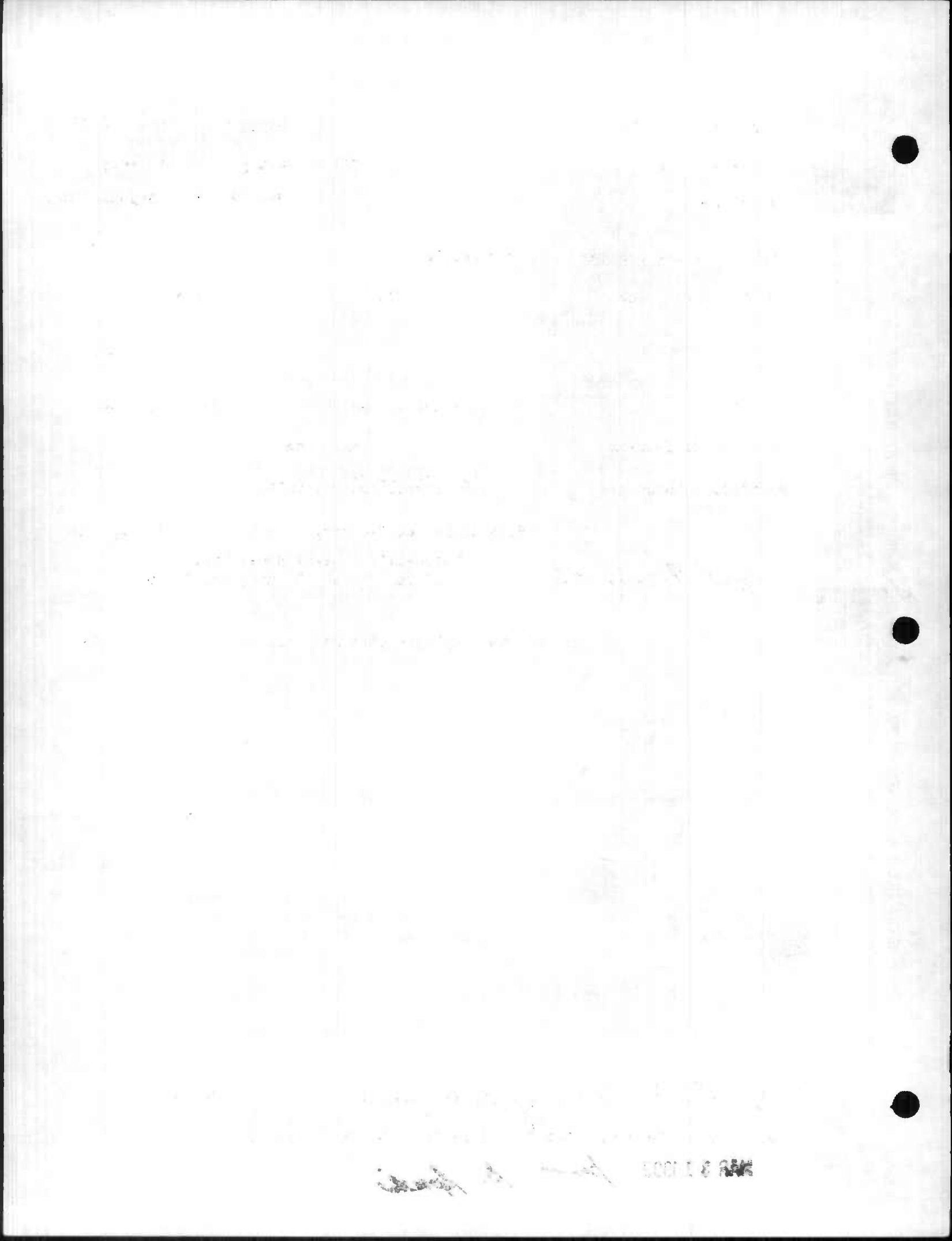
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12436  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELLA B. WILLIAMS

2. Date of Death  
Month Day Year  
MAR 25 99

3. Time of Death  
9:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

FORT WASHINGTON HOSPITAL

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number  
577-16-0711

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
90 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth (Month, Day, Year)  
June 28, 1908

9. Birthplace (State or Foreign Country)  
Sparta, Georgia

Usual Residence of Decedent

10a. State  
Maryland

10b. County  
Prince George's

10c. City, Town or Location  
WALDORF

10d. Inside City Limits  
☒ Yes 2 ☐ No

10e. Street and Number

2318 Love Place

10f. Zip Code

20601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 9th  
College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Supervisor of Maintenance

16b. Kind of Business/Industry  
Federal Govt.

17. Father's Name (First, Middle, Last)

Will Morse

18. Mother's Name (First, Middle, Maiden Surname)

Lillie (maiden unknown) Morse

19a. Informant's Name/Relationship (Type, Print)

Eloise King/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2813 Oxon Park St. Temple Hills, Md 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

3-31-99

20c. Location - City or Town, State

LANDOVER, MARYLAND

21. Signature of Funeral Service Licensee

*Shawana L. Blanton*

22. Name and Address of Facility

Marshall's Funeral Home of MD  
4308 Suitland Rd. Suitland, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

*Respiratory Failure.*

Due to (or as a consequence of):

b.

*Metastatic Breast Carcinoma.*

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Feeding dysfunction*

*hypoparathyroidism*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Edgar V. Potter*

29c. License number

009565

29d. Date signed (Month, Day, Year)

3-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edgar V. Potter 1328 Southern Ave. SE. Washington, DC 20032

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

*B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12437

Amend. item # 5. Per FH PGC 4-12-99 cr

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY E. WILSON

2. Date of Death

Month Day Year  
MAR. 28, 1999

3. Time of Death

8:08 AM

4a. Facility Name (If not institution, give street and number)

NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY CO.

5. Social Security Number

~~223-01-7561~~  
207-18-8475

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 16, 1912

9. Birthplace (State or Foreign Country)

KENTUCKY

Usual Residence of Decedent

10a. State

VA

10b. County

CHESTERFIELD

10c. City, Town or Location

RICHMOND

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4910 WAYCREST TERRACE

10f. Zip Code

23234

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NATIONAL SECURITY

16b. Kind of Business/Industry

DEPT. OF DEFENSE

17. Father's Name (First, Middle, Last)

WILLIAM PARIS BOWLING

18. Mother's Name (First, Middle, Maiden Surname)

ADDA MABEL BOWYER

19a. Informant's Name/Relationship (Type, Print)

CHARLES WILSON- HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4910-WAYCREST TERR., RICHMOND, VA. 23234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKLAWN CEMETERY

Date

3/31/99- ROCKVILLE, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*W. M. Hyson*

22. Name and Address of Facility

HYSONG CO., INC.  
1300- N ST., NW, WASH., DC

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Left sided congestive heart failure*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*1 month*

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Arteriosclerotic Coronary Artery Disease*

Due to (or as a consequence of):

*20 years*

c. *Hypertension Benign Essential*

Due to (or as a consequence of):

*30 years*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Alzheimer's Dementia, Gastroesophageal reflux  
osteoporosis*

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Behrman*

29c. License number

*D36618*

29d. Date signed (Month, Day, Year)

*March 28, 1999*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. C. SCHEMM- 9701- VEIRS DR., ROCKVILLE, MD. 20850

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

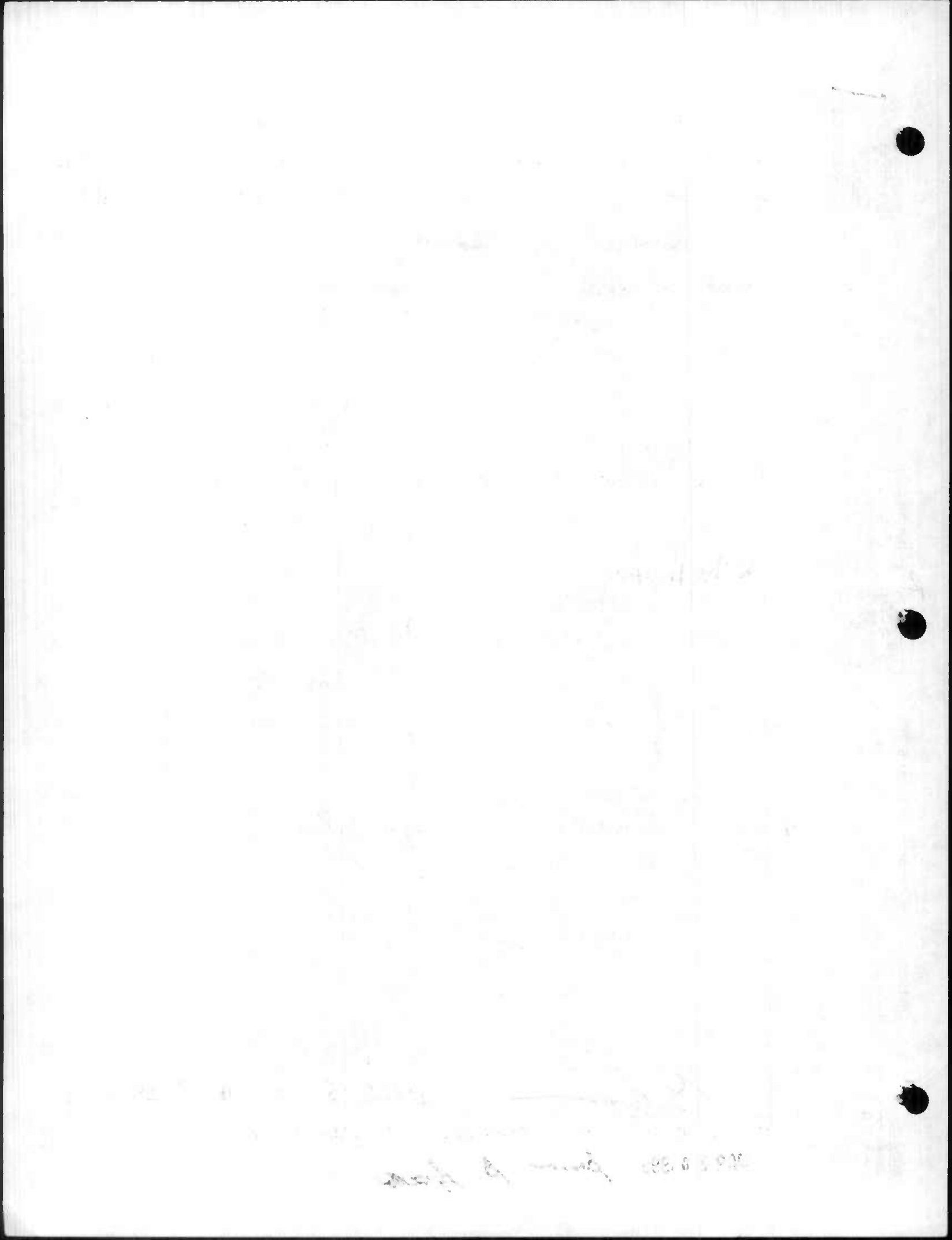
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be approved within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

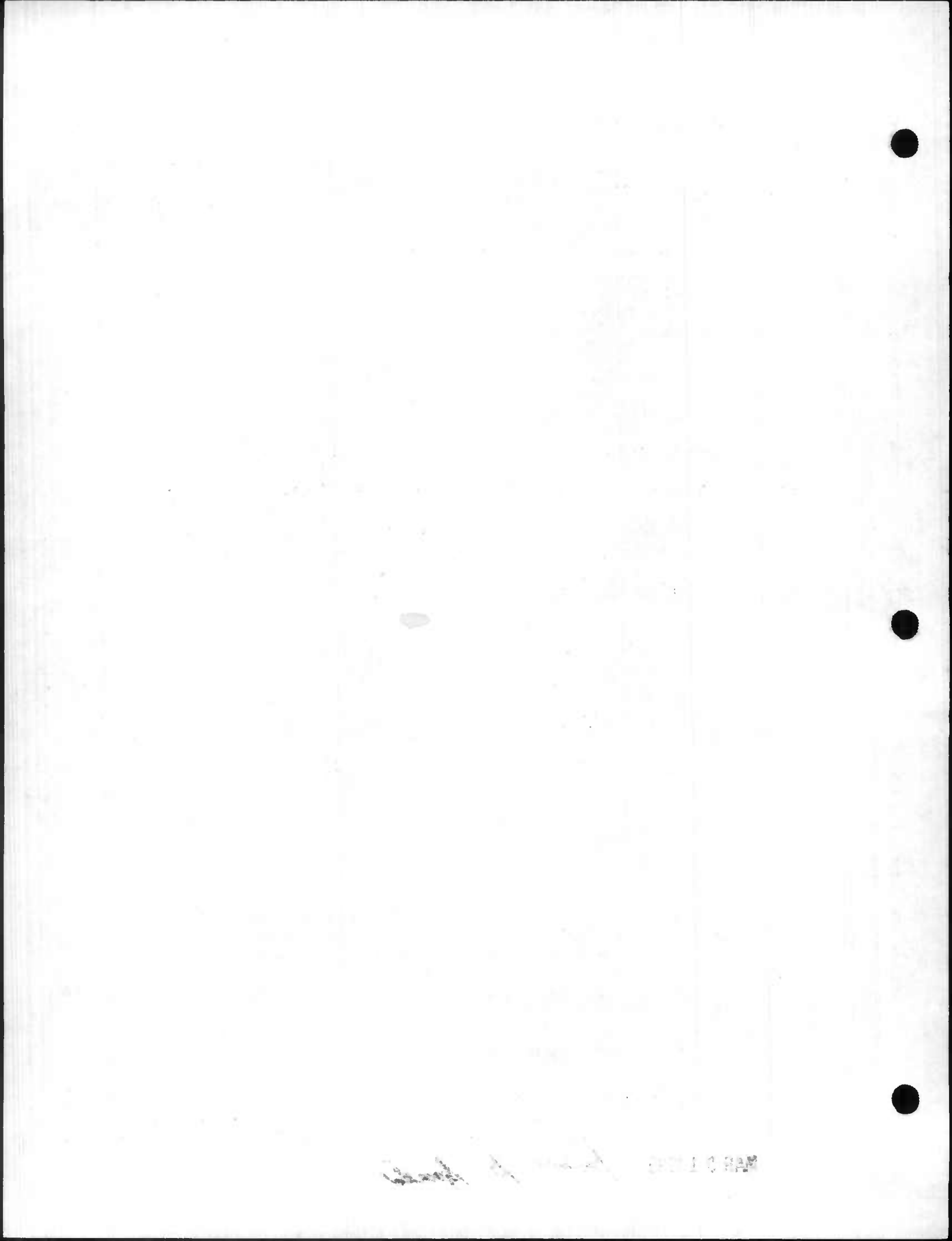
99 12438

|   |   |                           |   |  |   |                                      |  |  |  |  |  |
|---|---|---------------------------|---|--|---|--------------------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Edward Earle Wells                        |                           |   |  | 2. Date of Death<br>Month Day Year<br>3 27 99   |                                      |  |  | 3. Time of Death<br>2:32 AM                            |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital |                           |   |  | 4b. City, Town, or Location of Death<br>Silver Spring   |                                      |  |  | 4c. County of Death<br>Montgomery                      |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>578-24-8090  |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>87 Yrs.   |                                      | 8. Date of Birth (Month, Day, Year)<br>01-16-12                                      |  | 9. Birthplace (State or Foreign Country)<br>Newark, NJ |  |  |
|   | Usual Residence of Decedent   |                           |   |  |   |                                      |  |  |  |  |  |
| 10a. State<br>MD  |   | 10b. County<br>Montgomery |   | 10c. City, Town or Location<br>Silver Spring   |   |                                      |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br>8505 Springvale Rd.   |   |                           |   | 10f. Zip Code<br>20910   |   | 10g. Citizen of What Country?<br>USA |  |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                               |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4 yrs.  |   |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Postal Worker |   |                                      | 16b. Kind of Business/Industry<br>Postal Service                                     |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Earle Henry Wells  |   |                           |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Alice Polk   |                                      |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Matthew Shannon, ? Atty.  |   |                           |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1420 N St., N.W. Ste 308, Wash., DC 20005  |                                      |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Maryland National   |  | Date<br>4-1-99  |                                      | 20c. Location - City or Town, State<br>Laurel, Md.                                   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Ralph Williams</i>  |   |                           |   |  | 22. Name and Address of Facility<br>Ralph Williams Funeral Service<br>517 11th St., SE, Wash., DC 20003   |                                      |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>pulmonary embolus</i><br>Due to (or as a consequence of):<br>b. <i>deep venous thrombosis</i><br>Due to (or as a consequence of):<br>c. <i>hyperosmolar coma</i><br>Due to (or as a consequence of):<br>d. <i>diabetes mellitus</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                           |   |  |   |                                      |  |  |  | Approximate Interval Between Onset and Death<br>instant<br>days<br>days<br>years   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>pneumonia</i>  |   |                           |   |  |   |                                      |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                           |   |  |   |                                      |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                      |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |                           | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                      |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |                                      |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                           |   |  |   |                                      |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Roy Fried MD</i>  |   |                           |   |  | 29c. License number<br>D34590   |                                      | 29d. Date signed (Month, Day, Year)<br>3-27-1999                                     |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Roy Fried, MD, Kaiser HSM office, 1500 Forest Glen Rd, Silver Spring, MD</i>   |   |                           |   |  |   |                                      |  |  |  |  |  |
| 31. Date (Month, Day, Year)<br>MAR 31 1999  |   |                           |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |                                      |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12439

|   |   |   |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|---|---|---|--|--|--|---|--|---|---|---------------------------|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RAYMOND LAVERNE WOLF</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 29 1999</b>   |  | 3. Time of Death<br><b>0145</b>   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>8645 NORTH BEND CIRCLE</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>EASTON</b>  |  | 4c. County of Death<br><b>TALBOT</b>                                    |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>208-20-7252</b>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 25, 1929</b>             |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |   | 10e. State<br><b>MD</b>   |  | 10b. County<br><b>TALBOT</b>   |  | 10c. City, Town or Location<br><b>EASTON</b>                            |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10f. Zip Code<br><b>21601</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates <b>1949-1952</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>COMPUTER PROGRAMER</b>                                 |  | 16b. Kind of Business/Industry<br><b>U.S. GOVERNMENT</b>   |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>HERMAN J. WOLF</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>RUTH M. MILLER</b>   |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>DARLENE E. WOLF/ WIFE</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8645 NORTH BEND CIRCLE, EASTON, MD 21601</b>   |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OXFORD CEMETERY</b>  |  | Date<br><b>4-1-99</b>  |  | 20c. Location - City or Town, State<br><b>OXFORD, MD</b>                |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, P.A.<br/>200 S. HARRISON ST., EASTON, MD 21601</b>   |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | <table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last             </td> <td rowspan="4">                 e. Due to (or as a consequence of):<br/><br/>                 b. Due to (or as a consequence of):<br/><br/>                 c. Due to (or as a consequence of):<br/><br/>                 d.             </td> <td colspan="6"> <b>Myocardial Infarct</b> </td> </tr> <tr> <td colspan="6">                 Approximate Interval Between Onset and Death<br/> <b>24 hrs</b> </td> </tr> <tr> <td colspan="6"></td> </tr> <tr> <td colspan="6"></td> </tr> </table> |   |   |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | e. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. | <b>Myocardial Infarct</b> |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>24 hrs</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | e. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.   | <b>Myocardial Infarct</b>   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>24 hrs</b>   |   |   |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |   |   |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |   |   |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |   |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>        |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred      |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>H0053459</b> |  | 29d. Date signed (Month, Day, Year)<br><b>3/31/99</b>                                |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>DAVID BOEHMER, M.D., 216 S. WASHINGTON ST., EASTON, MD 21601</b>   |   |   |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1999</b>   |   | 32. Registrar's Signature<br>   |   |  |  |  |   |  |   |   |                           |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



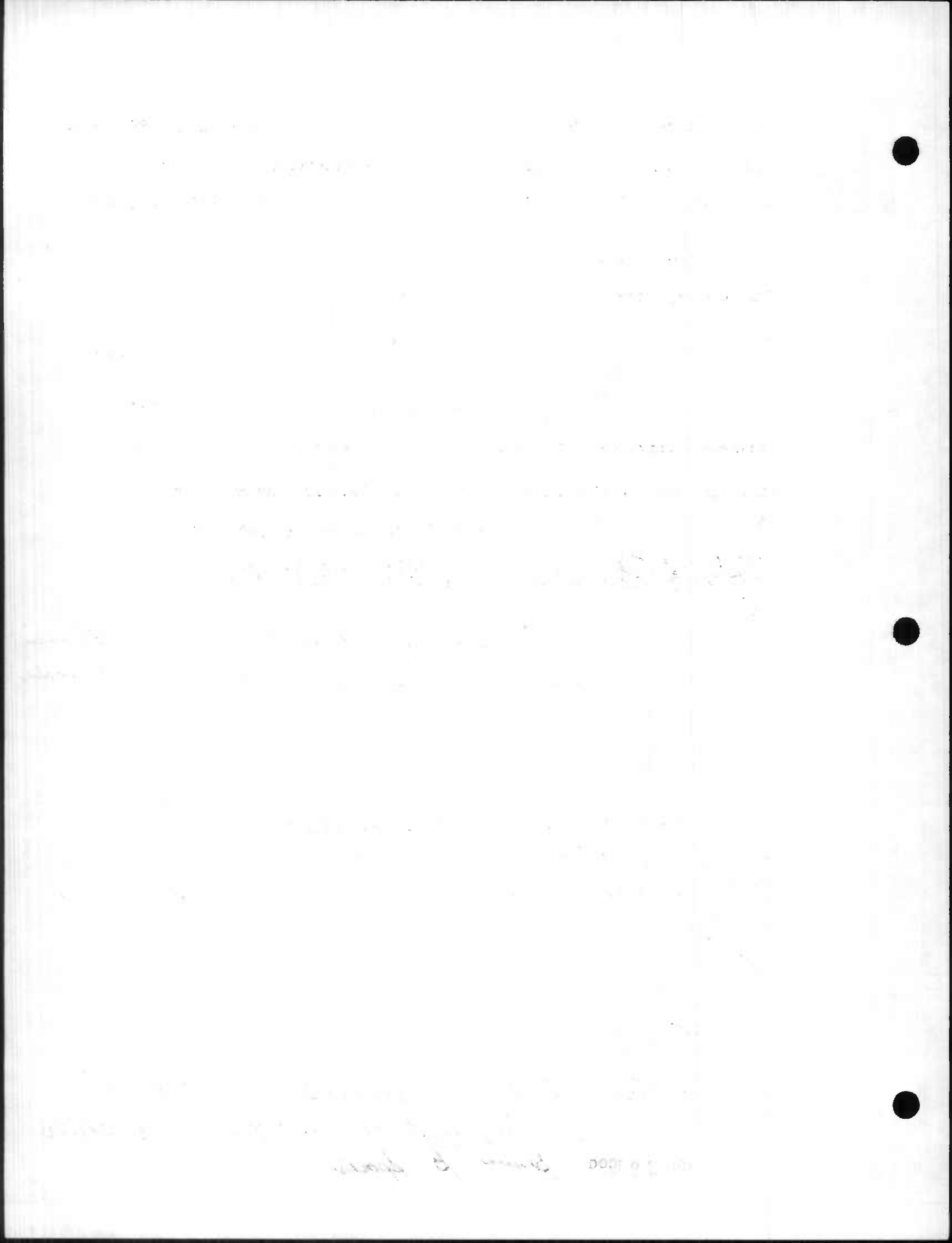
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12440

## Certificate of Death

Reg. No.

|   |   |   |                           |  |  |  |   |  |   |                                   |   |
|---|---|---|---------------------------|--|--|--|---|--|---|-----------------------------------|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Wesley Winchester</b>                               |   |                           |  |  |  | 2. Date of Death<br>Month Day Year<br><b>March 25 1999</b>  |  | 3. Time of Death<br><b>1858</b>                             |                                   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Kent &amp; Queen Anne's Hospital</b> |   |                           |  |  |  | 4b. City, Town, or Location of Death<br><b>Chestertown</b>  |  | 4c. County of Death<br><b>Kent</b>                          |                                   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-76-4680</b>   |   | 6. Sex<br><b>15 M 2 F</b> |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 30, 1921</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |                                   |   |
|   | Usual Residence of Decedent   |   |                           |  |  |  | 10a. State<br><b>Maryland</b>                               |  | 10b. County<br><b>Queen Annes</b>                           |                                   | 10c. City, Town or Location<br><b>Barclay</b> |
| To Be Completed by Funeral Director   |   | 10e. Street and Number<br><b>1305 Barclay Road</b>  |                           | 10f. Zip Code<br><b>21607</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |   |                                   |   |
|   |   | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b> |   | 14. Race - American Indian, Black, White, etc.<br><b>Specify: Black</b>                          |   |                                   |   |
|   |   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 2 College (1-4 or 5+)</b>   |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Never Worker</b>                     |  | 16b. Kind of Business/Industry<br><b>Never Worker</b>  |   |  |   |                                   |   |
|   |   | 17. Father's Name (First, Middle, Last)<br><b>Benjamin Harrison Winchester</b>  |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nolena Rochester</b>   |  |  |   |  |   |                                   |   |
|   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charlotte Ethel Butler, sister</b>   |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1305 Barclay Rd., Barclay, Maryland 21607</b>    |  |  |   |  |   |                                   |   |
|   |   | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rochester Memorial Cem.</b>   |  | 20c. Location - City or Town, State<br><b>4/3/99 Barclay, Maryland</b>   |   |  |   |                                   |   |
|   |   | 21. Signature of Funeral Service Licensee<br><b>John A. Prince</b>  |                           | 22. Name and Address of Facility<br><b>Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601</b>   |  |  |   |  |   |                                   |   |
|   |   | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pulmonary arrest</b>  |                           |  |  | Approximate Interval Between Onset and Death<br><b>45 min.</b>   |   |  |   |                                   |   |
| Physician<br>/Medical<br>Examiner   |   | Immediate Cause (Final disease or condition resulting in death)<br><b>Extensive pneumonia, bilateral</b>  |                           | Due to (or as a consequence of):   |  |  |   | Approximate Interval Between Onset and Death<br><b>3 weeks</b>                                   |   |                                   |   |
|   |   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |                           | Due to (or as a consequence of):   |  |  |   |  |   |                                   |   |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. |   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>① Mental Retardation ② Recurrent aspirations ③ Coronary artery disease ④ Congestive Heart Failure ⑤ CHF</b>  |                           |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |   |                                   |   |
|   |   | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |  |  |   |  |   |                                   |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner  |   | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |                           | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |  |   |  |   |                                   |   |
|   |   | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |                           | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |   | 28d. Describe how injury occurred |   |
|   |   | 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |                           | 29b. Signature and title of certifier<br><b>William M.D.</b>   |  | 29c. License number<br><b>D21313</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/29/99</b>  |   |                                   |   |
|   |   | 30. Name and address of person who completed causa of death (Item 23e) (Type, Print)<br><b>KIN K. WUN, 223 High St., Chestertown, MD 21620</b>  |                           |  |  |  |   |  |   |                                   |   |
| State Registrar   |   | 31. Date filed (Month, Day, Year)<br><b>MAR 29 1999</b>   |                           | 32. Registrar's Signature<br><b>James S. Sparks</b>  |  |  |   |  |   |                                   |   |
|   |   |   |                           |  |  |  |   |  |   |                                   |   |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12441

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary E. Wharton

2. Date of Death

Month Day Year  
March 29, 1999

3. Time of Death

1645

4a. Facility Name (If not institution, give street and number)

220 Melbourne Boulevard

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

215-32-0247

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 18, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

220 Melbourne Boulevard

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

in her own home

17. Father's Name (First, Middle, Last)

Arthur R. Boyer

18. Mother's Name (First, Middle, Maiden Surname)

Florence M. Kirkley

19a. Informant's Name/Relationship (Type, Print)

Tina M. Palmer/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Saddler Avenue, Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Elkton Cemetery

Date

April 1,  
1999

20c. Location - City or Town, State

Elkton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hicks Home for Funerals, P.A.  
103 West Stockton Street, Elkton, Maryland 2192123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. acute myocardial infarction  
Due to (or as a consequence of):

b. ASCVD

Due to (or as a consequence of):

c. COPD

Due to (or as a consequence of):

d. Emphysema

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Rheumatoid arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. John C. Han MD

29c. License number

D04023

29d. Date signed (Month, Day, Year)

3/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIA CHIH HSU MD

223 West Main St Elkton MD

31. Date filed (Month, Day, Year)

APR 01 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





State of Maryland / Department of Health and Mental Hygiene 99 12442  
Certificate of Death Reg. No.

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)  
Charles Edward Walker

2. Date of Death  
Month Day Year  
March 24, 1999

3. Time of Death  
6:30 am

4a. Facility Name (If not institution, give street and number)  
Carroll County General Hospital

4b. City, Town, or Location of Death  
Westminster

4c. County of Death  
Carroll

5. Social Security Number  
214-34-3945

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)  
66 Yrs.

8. Date of Birth (Month, Day, Year)  
Apr 21, 1932

9. Birthplace (State or Foreign Country)  
Maryland

10a. State  
Maryland

10b. County  
Carroll

10c. City, Town or Location  
Manchester

10d. Inside City Limits  
☐ Yes ☒ No

10e. Street and Number  
3400 Lineboro Road

10f. Zip Code  
21102

10g. Citizen of What Country?  
USA

11. Marital Status  
☐ Navar Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 8  
College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Truck Driver

16b. Kind of Business/Industry  
Construction

17. Father's Name (First, Middle, Last)  
Charles H. Walker

18. Mother's Name (First, Middle, Maiden Summa)  
Alverta M. Giggard

19a. Informant's Name/Relationship (Type, Print)  
Doris Walker, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
3400 Lineboro Road, Manchester, MD 21102

20a. Method of Disposition  
☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Trenton Cemetery

20c. Location - City or Town, State  
3/26 Upperco, MD

21. Signature of Funeral Service Licensee  
Eline Funeral Home

22. Name and Address of Facility  
934 South Main St, Hampstead, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediata Cause (Final disease or condition resulting in death)  
a. METASTATIC COLON CA  
Dua to (or as a consequence of):  
b.   
Dua to (or as a consequence of):  
c.   
Dua to (or as a consequence of):  
d.   
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Did tobacco use contribute to the cause of death?  
☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?  
☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)  
Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA  
Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death  
☒ Natural ☐ Pending investigation  
☐ Accidental ☐ Could not be determined  
☐ Suicidal ☐ Homicidal

28a. Date of Injury (Month, Day Year)

28b. Time of Injury  
M

28c. Injury at Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
Dr. [Signature] MD

29c. License number  
D35398

29d. Date signed (Month, Day, Year)  
3-24-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
Flavio Kruter, MD 224 Washington Hts Westminster MD 21157

31. Date filed (Month, Day, Year)  
MAR 31 1999

32. Registrar's Signature  
[Signature]

State Registrar

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Physician  
/Medical  
Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12443

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Phillip C. Yates

2. Date of Death

Month  
MarchDay  
28Year  
1999

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

Collingswood Nursing Center

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

579-22-0148

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

Aug. 19, 1925 Wash., D.C.

9. Birthplace (State or Foreign Country)

Funeral  
Director

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

299 Hurley Ave.

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: African American

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Textile Designer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John F. Yates

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Mallory

19a. Informant's Name/Relationship (Type, Print)

Renee Cooper - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

541 E. 20th St., New York, N.Y. 10010

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lee's Crematory

Date

3/30/99

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e.

Congestive Heart Failure

Due to (or as a consequence of):

Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Hypertension

Due to (or as a consequence of):

Years.

c.

Dementia

Due to (or as a consequence of):

Years.

d.

Diabetes Mellitus

Due to (or as a consequence of):

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. A. M. A. L. Y.

29c. License number

45843

29d. Date signed (Month, Day, Year)

March 28th 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S. A. M. A. L. Y. 481 N. Frederick Ave #230 Gaithersburg MD 20877

31. Date filed (Month, Day, Year)

MAR 30 1999

32. Registrar's Signature

S. A. M. A. L. Y.

State  
Registrar

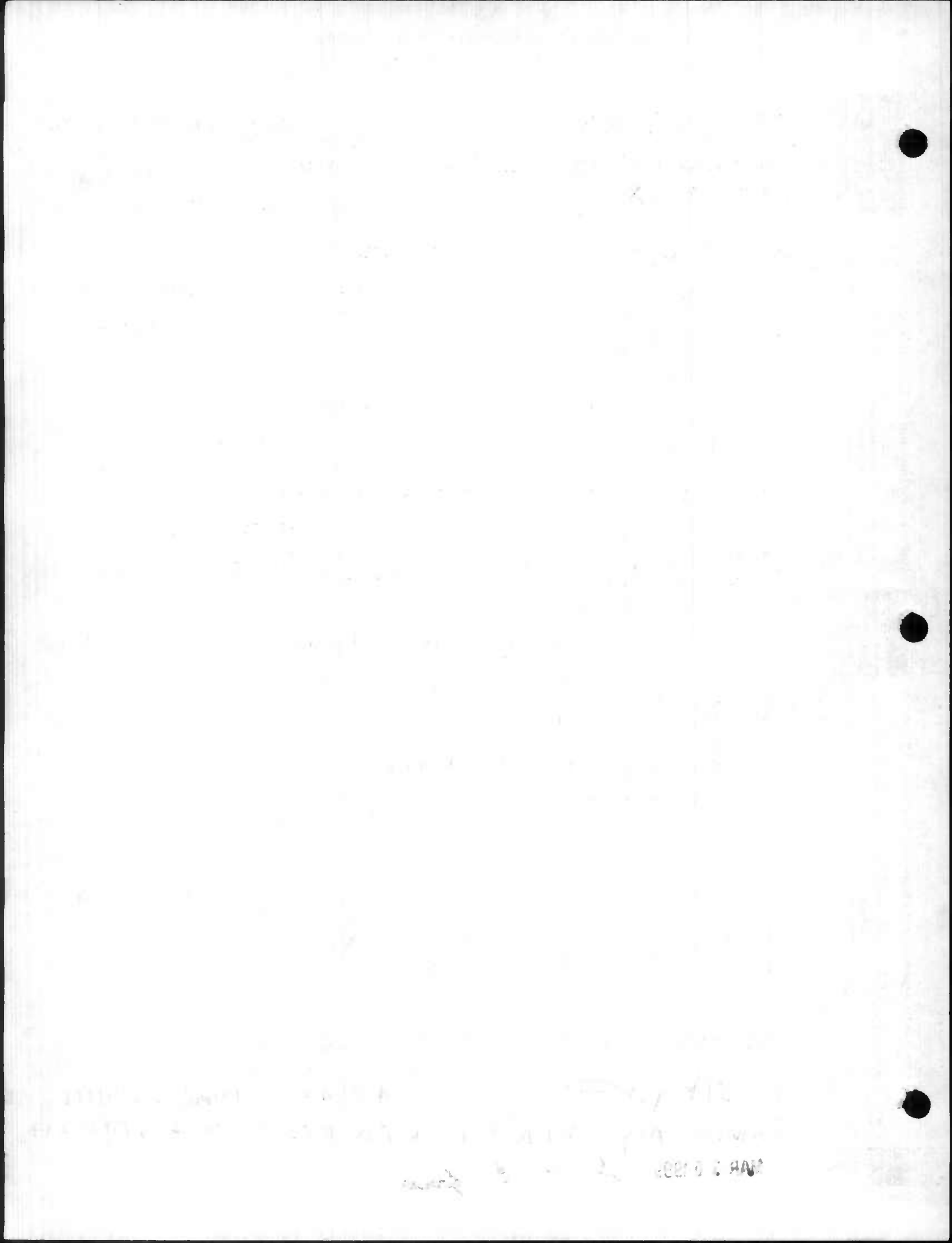
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12444

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Eduardo Z. Aguas

2. Date of Death

APRIL 11, 1999

3. Time of Death

01:07 AM

4a. Facility Name (If not institution, give street and number)

5200 ELMER STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-13-1862

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

19

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov. 27, 1979

9. Birthplace (State or Foreign)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

814 Milford Mill Rd.

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☒ Yes 2 ☐ No Specify: Puerto Rican

14. Race - American Indian,

Black, White, etc. Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Roofing Co.

17. Father's Name (First, Middle, Last)

William Aguas

18. Mother's Name (First, Middle, Maiden Surname)

Yvonne Wilkens

19a. Informant's Name/Relationship (Type, Print)

Mr. William Aguas (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 Lowergate Ct. Owings Mills, Md. 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest

Date

4/16/99

20c. Location - City or Town, State

Owings Mills Md

21. Signature of Funeral Service Licensee

Joseph L. Reuss

22. Name and Address of Facility

Joseph L. Reuss Funeral Home  
2222 W. North Ave. Balto, Md. 21216

23a. Place. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

SCENE

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☒ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

4-11-99

28b. Time of Injury

01-05

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office

Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5200 ELMER ST

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

OCME

29d. Date signed (Month, Day, Year)

APRIL 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 15 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12445

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Peter Allen

2. Date of Death

Month/

Day

Year

3. Time of Death

4 14 99 238pm

4a. Facility Name (If not institution, give street and number)

Good Samaritan Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

223-24-7987

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

97

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

05-04-01

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1530 Pentwood Road

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No  
Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Company

17. Father's Name (First, Middle, Last)

Prosser Allen

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Jacobs

19a. Informant's Name/Relationship (Type, Print)

Paula Gwynn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1530 Pentwood Road Baltimore, MD. 21239

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

1st. Bapt. Church Cem! 04-19-99 Hudgins, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Francis A. Gwynn

22. Name and Address of Facility

Baltimore, Maryland 21202  
WM C. March FH 1101 E. North Avenue23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

PROSTATE CANCER

Approximate  
Interval Between  
Onset and Death

1 YEAR

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James P. Richardson MD

29c. License number

027394

29d. Date signed (Month, Day, Year)

4/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James P. Richardson, M.D. 5601 Loch Raven Blvd. Baltimore, Md. 21239

31. Date filed (Month, Day, Year)

APR 15 1999

32. Registrar's Signature

James P. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar







State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No.

ITEMS: #23 PART I, 27 PER MEO G770 4-16-99 WR.

99 12446

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |   |                          |   |   |  |   |                                |  |                                    |  |  |  |
|---|---|--------------------------|---|---|--|---|--------------------------------|--|------------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Kevin Brown</b>                                  |                          |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 13 1999</b>   |   |                                |  | 3. Time of Death<br><b>12:39 A</b> |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b> |                          |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   |                                |  | 4c. County of Death<br><b>NA</b>   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-80-6751</b>   |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.   |   | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.     |  |  |  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>04-12-61</b>  |                          | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   |  |   |                                |  |                                    |  |  |  |
| Usual Residence of Decedent   |   |                          |   |   |  |   |                                |  |                                    |  |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>NA</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                    |  |  |  |
| 10e. Street and Number<br><b>4617 Marx Avenue</b>   |   |                          |   | 10f. Zip Code<br><b>21206</b>   |  |   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |                                    |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |                                    |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>NA</b>   |   |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Paver</b>   |  |   |                                | 16b. Kind of Business/Industry<br><b>ting Reliable Contrac-</b>  |                                    |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>McKever Brown</b>   |   |                          |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jeanette Christopher</b>  |  |   |                                |  |                                    |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jeanette Cates</b>   |   |                          |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21239 1310 Pentwood Road Baltimore, Maryland</b>   |  |   |                                |  |                                    |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kings Mem. Pk. Cem. 04-17-99 Randallstown, MD</b>  |  |   |                                | 20c. Location - City or Town, State  |                                    |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |                          |   | 22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>  |  |   |                                |  |                                    |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE ETHANOL AND NARCOTIC INTOXICATION</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |                          |   |   |  |   |                                |  |                                    |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                          |   |   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                    |  |  |  |
|   |   |                          |   |   |  |   |                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                    |  |  |  |
|   |   |                          |   |   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                    |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |                          |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |  |                                    |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined  |   |                          |   | 28a. Date of Injury (Month, Day, Year)<br><b>Found: 4-13-99</b>   |  | 28b. Time of Injury<br><b>UNKNOWN M</b> |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                    | 28d. Describe how injury occurred<br><b>UNKNOWN</b>          |  |  |
|   |   |                          |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND IN HOUSE</b>   |  |   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2529 E. OLIVER STREET BALTIMORE, MARYLAND</b>  |                                    |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                          |   | 29b. Signature and title of certifier<br>   |  |   |                                | 29c. License number<br><b>O.C.M.E</b>  |                                    | 29d. Date signed (Month, Day, Year)<br><b>APRIL 13, 1999</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |   |                          |   |   |  |   |                                |  |                                    |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |   |                          |   | 32. Registrar's Signature<br>   |  |   |                                |  |                                    |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |   |   |  |  |
|---|---|--|--|--|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Rena Baldwin</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 13 1999</b>  |  |   |   | 3. Time of Death<br><b>8:30 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Levindale Hebrew Geriatric Center</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |   |   | 4c. County of Death<br><b>n/a</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-14-5488</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>2/22/1924</b>                                     |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | Usual Residence of Decedent   |  |  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>n/a</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>144 North Haven Street</b>   |  |   |   | 10f. Zip Code<br><b>21224</b>  |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+)   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>In own home</b>  |  |   |   | 17. Father's Name (First, Middle, Last)<br><b>George Colgate Ness Jr.</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Florence Wolf</b>   |  |  |  | 19a. Informant's Name/Relationship (Type, Print) <b>son</b><br><b>Floyd R. Atkins Jr.</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>144 N. Haven St., Baltimore, Md. 21224</b>   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oaklawn</b>  |  |   |   | 20c. Location - City or Town, State<br><b>4/16/99 Baltimore, Maryland</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Maria M. Zannino</b>  |  |  |  | 22. Name and Address of Facility<br><b>Joseph N. Zannino Jr. Funeral Hm.<br/>263 S. Conkling St., Baltimore, Maryland 21224</b>   |  |   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>congestive heart failure</b><br>Due to (or as a consequence of):<br>b. <b>Arrhythmia</b><br>Due to (or as a consequence of):<br>c. <b>Coronary artery disease</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>76 months</b><br><b>76 months</b><br><b>76 months</b> |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |
|   | 28a. Date of Injury (Month, Day, Year)  |  |  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |
| 29b. Signature and title of certifier<br><b>M. Zannino</b>  |   |  |  | 29c. License number<br><b>D44817</b>   |   |  |   | 29d. Date signed (Month, Day, Year)<br><b>April 14 1999</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Amel B. Rejani 2434 W Belvedere Ave Baltimore, MD.</b> |   |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>                      |   |  |   | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12449

|   |   |  |  |  |   |  |  |   |  |
|---|---|--|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>LUCILLE MAGUIRE CAROZZA                   |  |  |  | 2. Date of Death<br>Month Day Year<br>April 11 1999 |  | 3. Time of Death<br>1:30 PM                          |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>ST. MARY'S HOSPITAL |  |  |  | 4b. City, Town, or Location of Death<br>LEONARDTOWN |  | 4c. County of Death<br>ST. MARY'S                    |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-16-0943  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>94 Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br>JUNE 25, 1904 |   |  |
|   | 9. Birthplace (State or Foreign Country)<br>MARYLAND                                  |  | 10a. State<br>MD   |  | 10b. County<br>ST. MARY'S                           |  | 10c. City, Town or Location<br>LEONARDTOWN           |   |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>34 MATTINGLY ST.   |   | 10f. Zip Code<br>20650   |  | 10g. Citizen of What Country?<br>U.S.A. |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) COLLEGE  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER   |  | 16b. Kind of Business/Industry<br>OWN HOME   |   |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>FRANCIS MAGUIRE  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARGARET MOORE  |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>ELIZABETH OSWALD/DAUGHTER   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>712 HUNTER WAY CATONSVILLE, MD 21228  |   |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>NEW CATHEDRAL CEMETERY   |  | Date<br>4/14/99  |   | 20c. Location - City or Town, State<br>BALTIMORE, MD   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |  |  | 22. Name and Address of Facility<br>STERLING-ASHTON-SCHWAB FUNERAL HOME, INC.<br>736 EDMONDSON AVE. CATONSVILLE, MD 21228  |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Cardiopulmonary Failure</i><br>Due to (or as a consequence of):<br><i>Septic Shock</i><br>Due to (or as a consequence of):<br><i>Urosepsis</i><br>Due to (or as a consequence of):<br><i>Urosepsis</i> |   | Approximate Interval Between Onset and Death<br><i>hrs.</i><br><i>hrs.</i><br><i>1 day</i>   |  |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>C.O.R.D.</i>   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                     |  | 28d. Describe how injury occurred       |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br>D 06419   |   | 29d. Date signed (Month, Day, Year)<br>4-11-99   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JAMES P. JARBOE M.D. PHILIP J. BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636   |   | 31. Date filed (Month, Day, Year)<br>APR 15 1999   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

LUCILLE MAGUIRE CAROZZA

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and complies with the law, it should be attached to the funeral director's certificate of cause of death.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 12450

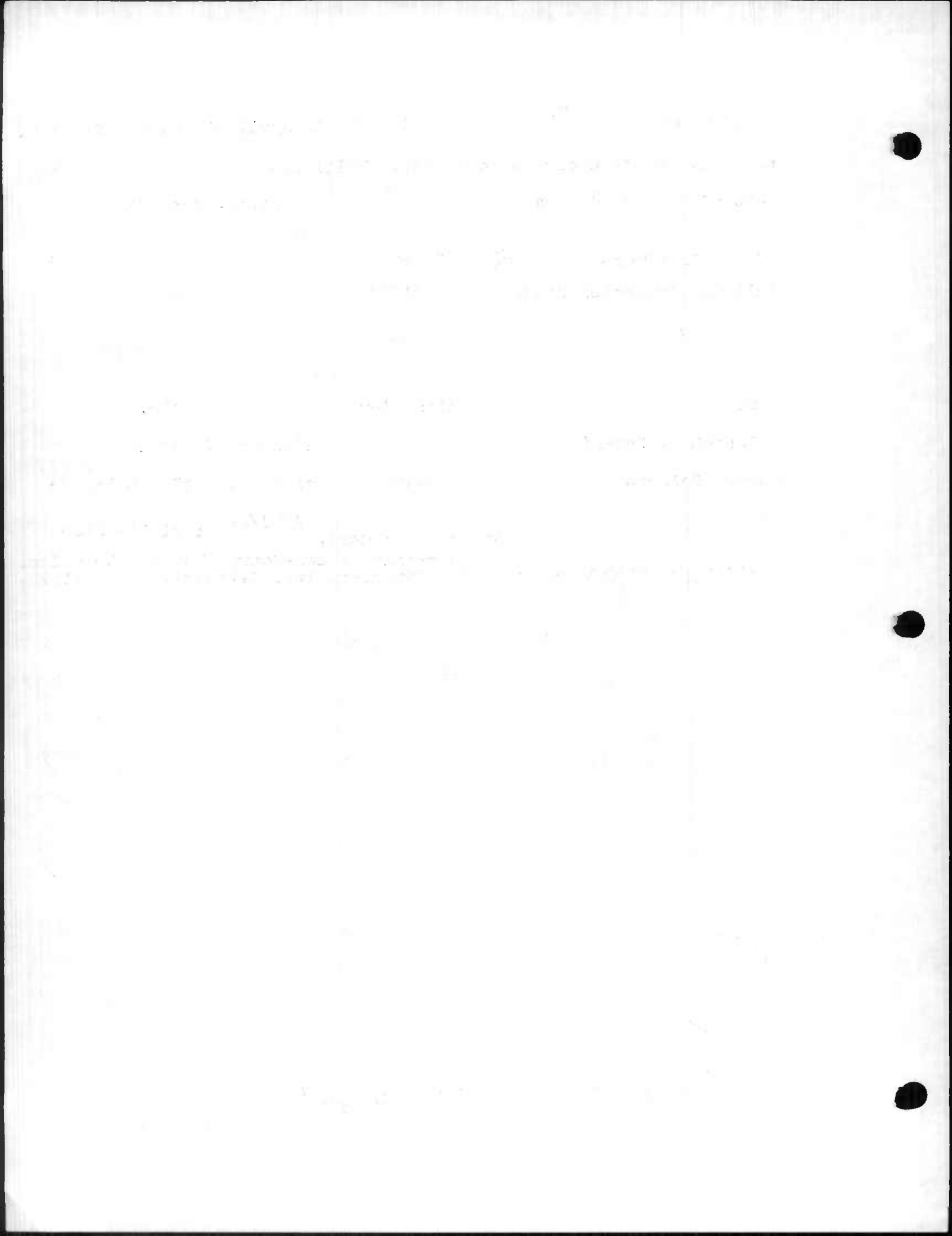
Certificate of Death

Reg. No.

|   |   |  |   |  |  |                                 |
|---|---|--|---|--|--|---------------------------------|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ANNA M. CALLENS</b>  |  | 2. Date of Death<br>Month Day Year<br><b>April 09, 1999</b>   |  | 3. Time of Death<br><b>5:20 P.M.</b>   |                                 |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Elizabeth's Nursing &amp; Rehab Cnt.</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |                                 |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-26-9689</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>01-12-1909</b> | 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |                                 |
|   | Usual Residence of Decedent   |  |   |  |  |                                 |
| To Be Completed by Funeral Director           | 10a. State<br><b>Md</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Catonsville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                 |
|   | 10e. Street and Number<br><b>1915 Old Frederick Road.</b>   |  | 10f. Zip Code<br><b>21228</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |                                 |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |  |                                 |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Clerk</b>                       |  | 16b. Kind of Business/Industry<br><b>Retail</b>  |                                 |
|   | 17. Father's Name (First, Middle, Last)<br><b>Joseph T. Gurski</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth (Olejnic)</b>   |  |  |                                 |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Andrew Callens</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21228 709 Maiden Choice Lane. Apt302 Balt. MD</b> |  |  |                                 |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crest Lawn Mem Gard.</b>   |  | 20c. Location - City or Town, State<br><b>Marriottsville</b>   |                                 |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Max K. Marshall</b>   |  | 22. Name and Address of Facility<br><b>Sterling-Ashton-Schwab Funeral Home Inc. 736 Edmondson Ave. Catonsville, MD 21228</b>                          |  |  |                                 |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |                                 |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. <b>DEHYDRATION</b> Due to (or as a consequence of): <b>WEEKS</b><br>f. <b>DYSPHASIA</b> Due to (or as a consequence of): <b>MONTHS</b><br>g. <b>CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of): <b>MONTHS</b><br>h. <b>ARTHEROSCLEROSIS</b> Due to (or as a consequence of): <b>YEARS</b>   |  |   |  |  |                                 |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>{   |  |   |  |  |                                 |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                 |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |                                 |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |  |                                 |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                 |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |  |                                 |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  |  | 28b. Time of Injury<br><b>M</b> |
|   | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |                                 |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                 |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |                                 |
|   | 29b. Signature and title of certifier<br><b>Noella Misquitta MD</b>   |  | 29c. License number<br><b>046449</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/12/99</b>  |                                 |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>NOELLA MISQUITTA, 3421 BENSON AVE SUITE 230 BALTIMORE MD 21227</b>   |  |   |  |  |                                 |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |  |   |  |  |                                 |
| State Registrar                               | 32. Registrar's Signature<br><b>G. Sparks</b>   |  |   |  |  |                                 |

Baltimore, Maryland 21215-0020  
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 important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12451

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760, R

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ANN CARAMEL</b>  |  | 2. Date of Death<br>Month <b>April</b> Day <b>11</b> Year <b>1999</b>  |   | 3. Time of Death<br><b>10:53 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b>  |  |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>              |
| 5. Social Security Number<br><b>216-01-0772</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br><b>12/25/1909</b>                |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |   |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |
| 10e. Street and Number<br><b>130 SLADE AVE. APT. 619</b>  |  |  | 10f. Zip Code<br><b>21208</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>       |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SECRETARY</b>                   |  | 16b. Kind of Business/Industry<br><b>PARK SCHOOL</b> |
| 17. Father's Name (First, Middle, Last)<br><b>SIMON MILLER</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CECILIA KLAFF</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DR. SIMON J. CARMEL/SON</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>25 BRANCHBROOK DR. HENRIETTA, NY. 14467</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HAR SINAI CONGREGATION</b>  |   | 20c. Date<br><b>4/13/99</b>  |  |
| 20d. Location - City or Town, State<br><b>OWINGS MILLS, MD</b>  |  | 21. Signature of Funeral Service Licensee<br>  |   |  |  |
| 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS. INC.<br/>8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   |  |  |
| 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |
| 29b. Signature and title of certifier<br> MD   |  | 29c. License number<br><b>D14505</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 11, 1999</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A. J. Imperatore, Jr. MD - wife.</b>   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 13 1999</b>   |  | 32. Registrar's Signature<br>  |   |  |  |

10

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene

99 12452

Item#29c,30 perDVR 4/15/99 EW

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>HERBERT DUBANSKY</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>April 11, 1999</b>  |  | 3. Time of Death<br><b>9:15 pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-12-0746</b>   |  | 6. Sex<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 21, 1919</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><b>1</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>6992 MILBROOK PARK DRIVE #1C</b>  |  |  |  |
|   | 10f. Zip Code<br><b>21215</b>   |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>DELIVERY PERSON</b>   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BEDDING COMPANY</b>   |  | 16b. Kind of Business/Industry<br><b>BEDDING COMPANY</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>ISADORE DUBANSKY</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>RAY SUSSMAN</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>LIBBY WEIS / SISTER</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8401 CHURCH LANE - RANDALLSTOWN, MD 21133</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW CEMETERY 4/13/99</b>   |  | 20c. Location - City or Town, State<br><b>REISTERSTOWN, MD</b>   |  | 20d. Date<br><b>4/13/99</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Ischemic Cardiomyopathy</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pulmonary Hypertension</b>   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input checked="" type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><b>1</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br><b>April 11, 1999</b>  |  | 28b. Time of Injury<br><b>M</b>  |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury et Work?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>  |  |  |  |
|   | 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Michael Hieb MD</b>  |  | 29c. License number<br><b>P11931</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 11, 1999</b>   |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael Hieb MD. Sinai Hospital Baltimore, Md</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 14 1999</b>  |  |  |  |
|   | 32. Registrar's Signature<br>   |  |  |  | 33. Date of Death<br><b>APR 11 1999</b>  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 2,29d per M.D G-770 4/28/99 reb

Certificate of Death

Reg. No.

99 12453

|   |   |  |  |  |  |                                 |   |  |
|---|---|--|--|--|--|---------------------------------|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Denise D. Edwards</b>  |  |  |  | 2. Date of Death<br>Month: <b>April</b> Day: <b>10</b> Year: <b>1999</b>   |                                 | 3. Time of Death<br><b>3:35 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris at Towson</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                 | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-58-8497</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 10, 1953</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>  |                                 | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>1817 Ruxton Ave.</b>  |                                 | 10f. Zip Code<br><b>21216</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African American</b>   |                                 | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>             |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse's Assistant</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Hospice</b>   |                                 |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Calvin Murphy</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Murphy</b>   |                                 |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Michael Edwards (Husband)</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1817 Ruxton Ave. Balto. Md. 21216</b>  |                                 |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion</b>  |                                 | 20c. Location - City or Town, State<br><b>4/16/99 Lansdowne, Md.</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>  |  |  |  | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</b>   |                                 |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Carcinoma of Rectum</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>1 yr.</b>   |                                 |   |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                 |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                 |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |                                 |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   |  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b> |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 28d. Describe how injury occurred  |  |                                 |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                 |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  | 29b. Signature and title of certifier<br><b>Joseph L. Russ</b>   |  |                                 |   |  |
| 29c. License number<br><b>D30641</b>  |   |  |  | 29d. Date signed (Month, Day, Year) <b>4/12/99</b>   |  |                                 |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>RAMESH SABARATHI SUITE 308 821 N.E. UTAH ST. BALTIMORE MD 21201</b>  |   |  |  | 31. Data filed (Month, Day, Year)<br><b>APR 15 1999</b>  |  |                                 |   |  |
| 32. Registrar's Signature<br><b>James B. Sparks</b>   |   |  |  |  |  |                                 |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12454

|   |   |  |  |  |   |  |  |  |  |
|---|---|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Gilbert Epstein</i>                              |  |  |  | 2. Date of Death<br>Month <i>April</i> Day <i>10</i> Year <i>1999</i> |  | 3. Time of Death<br><i>11:40 AM</i>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Harbor Hospital Center</i> |  |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>              |  | 4c. County of Death<br><i>N/A</i>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>214-20-9972</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>74</i> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br><i>4/6/1925</i>  | 9. Birthplace (State or Foreign)<br><i>MARYLAND</i>  |  |
|   | Usual Residence of Decedent   |  |  |  |   |  |  |  |  |
| 10a. State<br><i>MD</i>   |   | 10b. County<br><i>BALTIMORE</i>  |  | 10c. City, Town or Location<br><i>BALTIMORE</i>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><i>14 POMONA SOUTH # 4</i>  |   |  |  | 10f. Zip Code<br><i>21208</i>  |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>OWNER</i>  |   | 16b. Kind of Business/Industry<br><i>RETAIL CLOTHING</i>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>THEODORE EPSTEIN</i>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>LILLIAN SCHWARTZMAN</i>  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>IRENE EPSTEIN/WIFE</i>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>14 POMONA SOUTH # 4 BALTIMORE, MD. 21208</i>   |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>BALTIMORE HEBREW CONG.</i>  |  | Date<br><i>4/13/99</i>   |   | 20c. Location - City or Town, State<br><i>REISTERSTOWN MD</i>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |  |  | 22. Name and Address of Facility<br><i>SOL LEVINSON &amp; BROS. INC.<br/>8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</i>  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Ventricular Fibrillation</i><br>Due to (or as a consequence of):<br><i>b. Acute Myocardial Infarction</i><br>Due to (or as a consequence of):<br><i>c. End-Stage Coronary Artery Disease</i><br>Due to (or as a consequence of):<br><i>d.</i> |   |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><i>30 minutes</i><br><i>45 minutes</i><br><i>20 years</i>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
|   |   |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Robert M. Yacynych MD</i>   |   |  |  | 29c. License number<br><i>D0052022</i>   |   | 29d. Date signed (Month, Day, Year)<br><i>April 10 1999</i>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Robert M. Yacynych 3001 South Hanover St Baltimore MD</i>  |   |  |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 15 1999</i>   |   | 32. Registrar's Signature<br><i>[Signature]</i> <i>21225</i>   |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12455

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ATHALIE FREEDMAN</b>                                |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 11, 1999</b>  |  | 3. Time of Death<br><b>4:15 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-38-6951</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>2 23 1913</b>                              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>LOUISIANA</b>                                       |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>RANDALLSTOWN</b>                                   |  |
| Usual Residence of Decedent   |  |  |   |  |  |  |  |  |
| 10e. Street and Number<br><b>3845 ELMCROFT ROAD</b>   |  |  |   | 10f. Zip Code<br><b>21133</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b> |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>3</b>  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>REGISTERED NURSE</b> |  |  | 16b. Kind of Business/Industry<br><b>MEDICINE</b>                                    |  |
| 17. Father's Name (First, Middle, Last)<br><b>HARRY MARKEY</b>  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EDNA GOLDENBERG</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SIDNEY FREEDMAN/HUSBAND</b>  |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3845 ELMCROFT ROAD RANDALLSTOWN, MD. 21133</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MIKRO KODESH BETH ISRAEL</b>   |  | Data<br><b>4/13/99</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MD.</b>                         |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Coronary Heart Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD; Lung CA</b>  |  |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28d. Describe how injury occurred   |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |  |   |  | 29c. License number<br><b>044007</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 11, 1999</b>                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A J Imperia, Jr. - NWHC</b>  |  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |  |  | 32. Registrar's Signature<br>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

State Registrar

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1392

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12456**  
**Certificate of Death**

Reg. No.

|   |   |  |   |   |  |   |  |  |  |  |  |  |
|---|---|--|---|---|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ROSE JEAN GOETZ</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 9, 1999</b>   |   |  |  | 3. Time of Death<br><b>10:30PM</b>   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2614 CLAYTON ROAD</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>FALLSTON</b>  |   |  |  | 4c. County of Death<br><b>HARFORD</b>  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-03-5401</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 2, 1917</b>                           |  | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>   |  |  |  |
|   | Usual Residence of Decedent   |  |   |   |  |   |  |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>HARFORD</b>   |   | 10c. City, Town or Location<br><b>FALLSTON</b>   |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
|   | 10a. Street and Number<br><b>2614 CLAYTON ROAD</b>  |  |   |   | 10f. Zip Code<br><b>21047</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b> |  |   | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                                    |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOHN B. VARILLO</b>   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY GRANDE</b> |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROSEMARY STRATTON/DAUGHTER</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>261 RIVERDALE RD. SEVERNA PARK, MD. 21146</b>  |   |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH CEM.</b>  |   |  |   | 20c. Location - City or Town, State<br><b>4/13/99 BALTIMORE, MD.</b>                 |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Elizabeth S. Zeiler</i>   |  |   |   | 22. Name and Address of Facility<br><b>CHARLES S. ZEILER &amp; SON, INC.<br/>6224 EASTERN AVE. BALTIMORE, MD. 21224</b>  |   |  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Coronary artery disease</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |  |   |   |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>8 mos</b> |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>dementia</u><br><u>pleural effusion</u>  |  |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |
|   |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |   |  |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br><i>Susan M. Friedman</i>   |  |   |   | 29c. License number<br><b>038679</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/12/99</b>                                |  |  |  |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Susan M. Friedman, MD 4940 Eastern Ave Baltimore MD 21224</b>  |  |   |   |  |   |  |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |   |  |   |  |  |  |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

99 12457

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Nathan Gamble</b>   |  |   |  | 2. Date of Death<br>Month, Day, Year<br><b>April 10, 1999</b>  |  | 3. Time of Death<br><b>0735</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3525 Oakmont Ave.</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>251-26-2664</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth<br>Month, Day, Year<br><b>May 15, 1923</b>  |  |
|   | Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>  |  |
| To Be Completed by Funeral Director           | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
|   | 10e. Street and Number<br><b>3525 Oakmont Ave.</b>   |  |   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housekeeper</b>                       |  | 16b. Kind of Business/Industry<br><b>University of Md.</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Robert Gamble</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Creola Chandler</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print) (daughter)<br><b>Mrs. Dorothy Jenkins</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1119 Wedgewood Rd. Balto. Md. 21229</b>  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion</b>   |  | 20c. Location - City or Town, State<br><b>4/15/99 Lansdowne, Md.</b>   |  | 20d. Date  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>   |  |   |  | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</b>   |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Mycosis Fungoides</b><br>Due to (or as a consequence of):<br><b>b. Lymphoma</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>Coronary Artery Disease</b><br><b>Hypertension</b>   |  |   |  |  |  | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  | 29b. Signature and title of certifier<br><b>Wanda J. Simms</b>   |  |
|   | 29c. License number<br><b>D35674</b>   |  |   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 12, 1999</b>   |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wanda J. Simms Chemistsmo 2513 Clearlake Johnson</b>  |  |   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>  |  |
|   | 32. Registrar's Signature<br><b>P. Sparks</b>  |  |   |  |  |  | 33. Date of Death<br><b>APR 10 1999</b>  |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12458

|   |  |   |  |  |   |  |  |   |  |
|---|--|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Teddy A. Horsley</b>  |   |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>14</b> Year <b>1999</b> |  | 3. Time of Death<br><b>08:59</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland Medical Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>         |  | 4c. County of Death<br><b>N/A</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-60-3448</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 16, 1952</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>OHIO</b> |  |
|   | Usual Residence of Decedent  |   |  |  |   |  |  |   |  |
| 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>839 S. OLDHAM STREET</b>   |  |   |  | 10f. Zip Code<br><b>21224</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1974-1976</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ASSEMBLER</b>  |   | 16b. Kind of Business/Industry<br><b>BAKERY</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>MARTIN HORSLEY</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FLORINE MILLER</b>   |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>TAMMIE TIMMONS/NIECE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>69 AVALON AVE. BALTIMORE, MD. 21222</b>  |   |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OAK LAWN CEMETERY</b>  |  | Date<br><b>4/17/99</b>   |   | 20c. Location - City or Town, State<br><b>BALTIMORE, md.</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Elizabeth Selinski</i>  |  |   |  | 22. Name and Address of Facility<br><b>CHARLES S. ZEILER &amp; SON, INC.<br/>6224 EASTERN AVE. BALTIMORE, MD. 21224</b>  |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Hemorrhage</b> Due to (or as a consequence of):<br>f. <b>Disseminated Intravascular Coagulation</b> Due to (or as a consequence of):<br>g. <b>Liver Dysfunction</b> Due to (or as a consequence of):<br>h. <b>Hepatitis C</b><br><br>Approximate Interval Between Onset and Death<br><b>15 hours</b><br><b>6 hours</b><br><b>unknown</b><br><b>unknown</b> |  |   |  |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Rheumatic Heart Disease. Pt was post-operative from Aortic and Mitral Valve Repairs</b>  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                       |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Maurice Boudet MD</b>   |  |   |  | 29c. License number<br><b>P10274</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 14, 1999</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>225. Greene Street, Department of Surgery, Baltimore, MD 21201</b>   |  |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |  |   |  | 32. Registrar's Signature<br><i>B. Sparks</i>  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

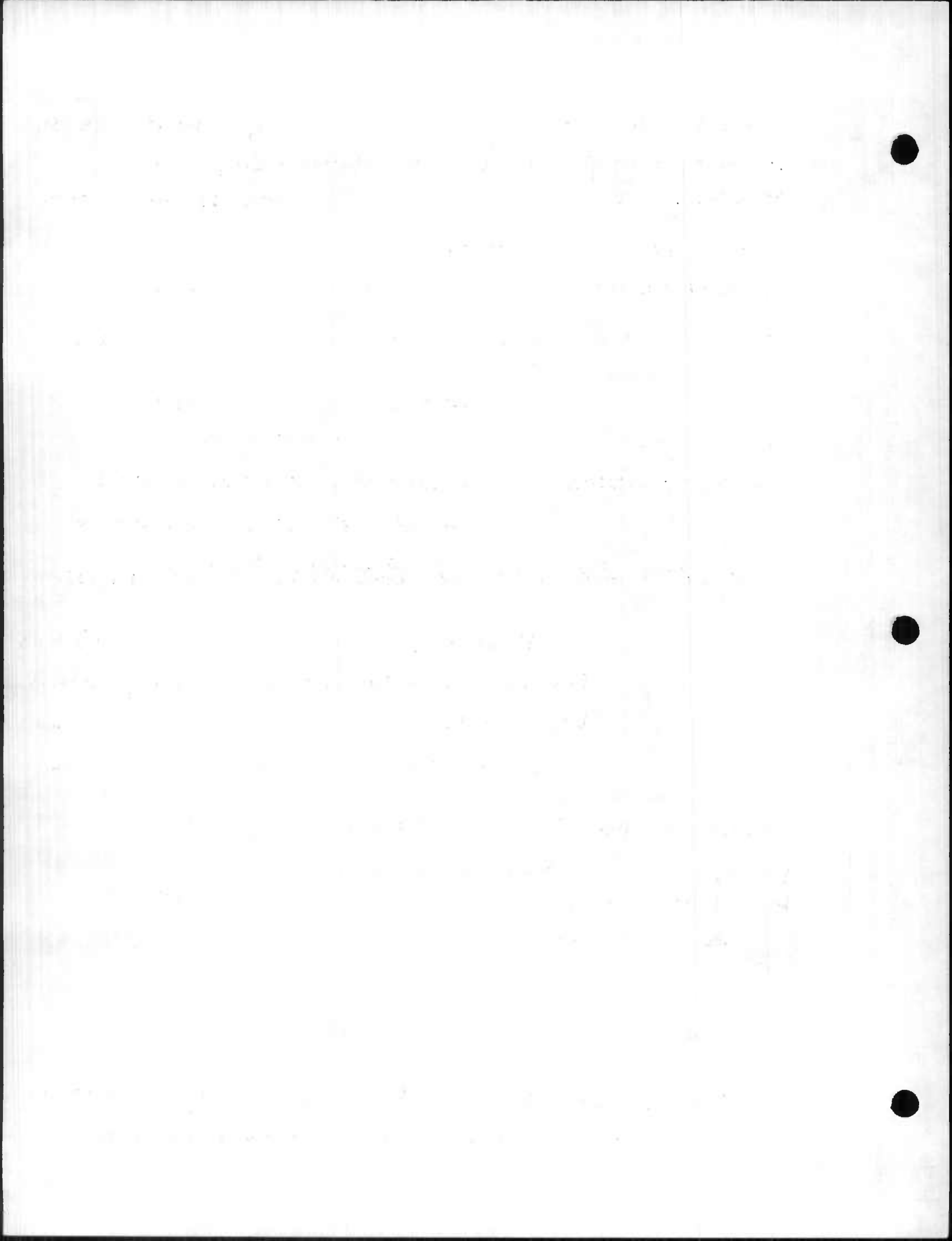
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12459

|   |   |                          |   |   |  |                                 |  |  |   |  |  |
|---|---|--------------------------|---|---|--|---------------------------------|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Matilda Hill</b>   |                          |   |   | 2. Date of Death<br>Month Day Year<br><b>April 13, 1999</b>  |                                 |  |  | 3. Time of Death<br><b>10:53 A.M.</b>                     |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1214 North Charles Street, Apartment 318</b> |                          |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                 |  |  | 4c. County of Death<br><b>N/A</b>                         |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>527-69-2143</b>   |                          | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>26</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>11-13-72</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Korean</b> |  |  |
|   | Usual Residence of Decedent   |                          |   |   |  |                                 |  |  |   |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>NA</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |                                 |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| 10e. Street and Number<br><b>1214 N. Charles Street Apt#318</b>   |   |                          |   | 10f. Zip Code<br><b>21201</b>   |  |                                 |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>1 1/2 yrs.</b>  |   |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>   |  |                                 |  | 16b. Kind of Business/Industry<br><b>Student</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joe Dave Hill</b>   |   |                          |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>O.K. Sun Kim</b>  |  |                                 |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>OK Nyon Kim</b>  |   |                          |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>48103</b><br><b>404 W. Liberty Street Andover, Michigan</b>  |  |                                 |  |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>  |  | Date<br><b>04-16-99</b>         |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |                          |   | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C.March FH 1101 e. North Avenue</b>   |  |                                 |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pulmonary Thromboembolism with Deep Vein Thrombosis</b><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                          |   |   |  |                                 |  |  |   | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                          |   |   |  |                                 |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |
|   |   |                          |   |   |  |                                 |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
|   |   |                          |   |   |  |                                 |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |                          |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |                          |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|   |   |                          |   | 28d. Describe how injury occurred   |  |                                 |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                          |   |   |  |                                 |  |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   |                          |   | 29c. License number<br><b>O.C.M.E.</b>  |  |                                 |  | 29d. Date signed (Month, Day, Year)<br><b>April 14, 1999</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>  |   |                          |   |   |  |                                 |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |   |                          |   | 32. Registrar's Signature<br>   |  |                                 |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12460

|   |  |                           |   |   |  |   |   |  |  |  |
|---|--|---------------------------|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EAST Himmelman</b>                              |                           |   |   |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>9<sup>th</sup></b> Year <b>1999</b> |  | 3. Time of Death<br><b>5:35 pm</b>                     |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Franklin Woods Centre</b> |                           |   |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                          |  | 4c. County of Death<br><b>Baltimore</b>                |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-05-2967</b>  |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 27, 1910</b>                       |  | 9. Birthplace (State or Foreign Country)<br><b>MD.</b> |  |
|   | Usual Residence of Decedent  |                           |   |   |  |   |   |  |  |  |
| 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>N/A</b> |   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>7102 GOUGH STREET</b>  |  |                           |   | 10f. Zip Code<br><b>21224</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b></b>   |  |                           |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CUSTOMER SERVICE REP.</b> |  |   | 16b. Kind of Business/Industry<br><b>GAS &amp; ELECTRIC</b>                       |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>UNKNOWN</b>   |  |                           |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>   |   |  |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>STEPHANIE SHEARER</b>  |  |                           |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>510 ARMSTRONG LANE BALTIMORE, MD. 21221</b>                                       |   |  |  |  |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>1 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE CEMETERY</b>   |   |  | Date<br><b>4/12/99</b>  |   | 20c. Location - City or Town, State<br><b>BALTIMORE, MD.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Barbara L. Smith MD00521</b>  |  |                           |   |   |  | 22. Name and Address of Facility<br><b>CHARLES S. ZEILER &amp; SON, INC.<br/>6224 EASTERN AVE, BALTIMORE, MD. 21224</b>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                           |   |   |  |   |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____   |  |                           |   |   |  |   |   |  |  |  |
| Approximate Interval Between Onset and Death<br><b>10 days</b>  |  |                           |   |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinsons Disease</b><br><b>Diabetes Mellitus</b>   |  |                           |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |  |
|   |  |                           |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |                           | 28e. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred                      |  |
|   |  |                           | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)      |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                           | 29b. Signature and title of certifier<br><b>Barbara L. Smith MD</b>   |   | 29c. License number<br><b>DS0757</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 9<sup>th</sup> 1999</b>           |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A.N. Ralapati: 9105 Franklin Square DR. Baltimore, MD 21237.</b>   |  |                           |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |  |                           | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12461

ITEMS: #23 PART I, 27 PER MEO G772 6-8-99 WR.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

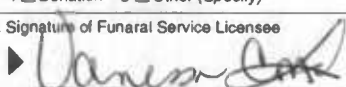

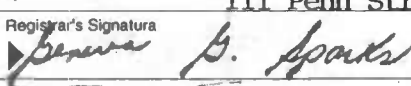
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |   |   |   |  |  |  |  |
|--|--|---|--|--|---|---|---|--|--|--|--|
| Physician / Medical Examiner   |  | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Edwin Harrison</b>  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>April 11, 1999</b>                                 |   | 3. Time of Death<br><b>4:37 A.M.</b>   |  |  |  |
| Funeral Director   |  | 4a. Facility Name (If not institution, give street and number)<br><b>Baltimore City Detention Center</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                    |   | 4c. County of Death<br><b>N/A</b>  |  |  |  |
|  |  | 5. Social Security Number<br><b>213-76-8310</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>41</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>10-16-57</b>   |  |  |  |
|  |  |   |  | If Under 1 Year<br>Months Days   |   | If Under 24 Hrs.<br>Hours Min.  |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |   |   |   |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br><b>900 Seagull Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21225</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>NA</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Trash Removal</b>  |   |   | 16b. Kind of Business/Industry<br><b>Donnie Trash Co.</b>               |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Emmitt E. Harrison</b>   |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Geraldine Willis</b>  |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Janice Harrison</b>   |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2516 Ashland Avenue Baltimore, MD 21205</b> |   |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Western Star Cem.</b> |  |   | Date<br><b>04-17-99</b>   |   | 20c. Location - City or Town, State<br><b>Catonsville, MD</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C.March FH 1101 E.North Avenue</b>                                |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ASPIRATION DUE TO CHRONIC NARCOTISM</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. _____</b><br>Due to (or as a consequence of):<br><b>c. _____</b><br>Due to (or as a consequence of):<br><b>d. _____</b> |  |   |  |  |   |   |   |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
|  |  |   |  |  |   |   |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
|  |  |   |  |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b> |  |  |   |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>  |  |  |   | 29c. License number<br><b>O.C.M.E.</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 11, 1999</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>  |  | 32. Registrar's Signature<br>   |  |  |   |   |   |  |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 12462**  
Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |
|--|---|---|--|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>Leon Curtis Hall, Sr.</b>                    |   | 2. Date of Death<br>Month Day Year<br><b>APR 12 1999</b>   |  | 3. Time of Death<br><b>0530 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Lorien Nursinghome</b> |   | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  | 4c. County of Death<br><b>Howard</b>                                      |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>231-10-4221</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>04/01/1907</b>   |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                 |   |  |  |   |  |
| Usual Residence of Decedent  |   |   |  |  |   |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>HOWARD</b>  |  | 10c. City, Town or Location<br><b>COLUMBIA</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>6334 CEDAR LANE</b>   |   |   | 10f. Zip Code<br><b>21044</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                            |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>EXECUTIVE</b>                          |  | 16b. Kind of Business/Industry<br><b>INDUSTRIAL FINANCIAL INSTITUTION</b> |  |
| 17. Father's Name (First, Middle, Last)<br><b>GEORGE M. HALL</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MINNIE WOOD</b>  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARGARET H. SCHRADER/DAUGHTER</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5633 COLUMBIA ROAD APT. 302 COLUMBIA, MD 21044</b> |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FOREST LAWN CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>NORFOLK, VA</b>  |   | Date<br><b>4/15/99</b>   |
| 21. Signature of Funeral Service Licensee<br>  |   |   | 22. Name and Address of Facility<br><b>STERLING-ASHTON-SCHWAB FUNERAL HOME, INC.</b><br><b>736 EDMONDSON AVE. CATONSVILLE, MD 21228</b>                |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebrovascular Accident</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>6 Months</b> |   |   |  |  |   | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinson's disease</b><br><b>Aspiration Pneumonia</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28d. Describe how injury occurred  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br> <b>MD</b>   |   | 29c. License number<br><b>D0052940</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APR 12 1999</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SANJAY P. SHAH, MD 10805 Hickory Ridge Road #210, Columbia, MD 21044</b>  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>  |   | 32. Registrar's Signature<br>   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH(12)

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

COURT

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 11 PER ORDER G774 8-31-99 WR.

## Certificate of Death

Reg. No.

99 12463

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael

2. Date of Death

April

Day

Year

12, 1999

3. Time of Death

4:10 PM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

425-98-2858

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

JUNE 09, 1953

9. Birthplace (State or Foreign Country)

MISSISSIPPI

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1962 WOODLAWN DRIVE, APT. H

10f. Zip Code

21207

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th GRADE

College (1-4 or 5+)

4 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

GRAIN INSPECTOR

16b. Kind of Business/Industry

U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

JOSEPH

18. Mother's Name (First, Middle, Maiden Surname)

EMMA (MNM-UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

BETTY PEOPLES (FIANCEE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1962 WOODLAWN DRIVE, BALTIMORE MD. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hollywood Cemetery

Date

4/17/99

20c. Location - City or Town, State

FAYETTE, MISS

21. Signature of Funeral Service Licensee

John J. Hill

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

HIV

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Medical Examiner2 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shannon Putman MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

April 12, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Shannon Putman MD Johns Hopkins Hospital, Baltimore, Maryland

31. Date filed (Month, Day, Year)

APR 15 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#1 perPHY G770 4/15/99 EW

## Certificate of Death

Reg. No.

99 12464

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HOLMAN

2. Date of Death

Month Day Year  
APRIL 10<sup>th</sup> 99

3. Time of Death

8:10 Am

4a. Facility Name (If not institution, give street and number)

Future Care Nursing Home

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214-56-8582

6. Sex

M 2 F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 11, 1952

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

55 Flaxton Court

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

Patapsco

Back River Railroad

17. Father's Name (First, Middle, Last)

Henry M. Holman

18. Mother's Name (First, Middle, Maiden Surname)

Christine E. Jones

19a. Informant's Name/Relationship (Type, Print)

Christine E. Holman

mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4011 Fairfax Road Baltimore, Md. 21216

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Lukes Cemetery

Date

April 15 Reisterstown, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Nutter Funeral Homes, Inc.  
2501 Gwynns Falls PKWY Baltimore, Md. 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

PNEUMONIA

Due to (or as a consequence of):

b.

END STAGE AIDS

Due to (or as a consequence of):

c.

NON HODGKINS LYMPHOMA.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident Investigation  
3 Suicide 6 Could not be  
4 Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
injury

M

28c. Injury at  
Work?

1 Yes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5309 A OLD COURT ROAD RANDALLSTOWN MD 21133

31. Date filed (Month, Day, Year)

APR 15 1999

32. Registrar's Signature

James B. Spack

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12465

|  |  |   |   |  |  |   |  |  |   |  |  |  |  |
|--|--|---|---|--|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ernest Jupiter</b>  |   |   |  |  |   | 2. Date of Death<br>Month: <b>April</b> Day: <b>13</b> Year: <b>1999</b>   |  |   | 3. Time of Death<br><b>12:46 am</b>                          |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Baltimore VA Medical Center</b>   |   |   |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |   | 4c. County of Death<br><b>N/A</b>                            |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>247-26-4479</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |   | If Under 1 Year<br>Months: Days:   |  | If Under 24 Hrs.<br>Hours: Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 01, 1920</b>                                    |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>SOUTH CAROLINA</b>  |   |   |  |  |   |  |  |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |   |  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br><b>2421 GUILFORD AVENUE</b>  |   |   |  | 10f. Zip Code<br><b>21218</b>  |   |  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>7TH GRADE</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CARPENTER</b>  |   |  |  | 16b. Kind of Business/Industry<br><b>SELF-EMPLOYED</b>                  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>HENSON</b>   |   |   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JUPITER JOSEPHINE (MN-UNKNOWN)</b>   |  |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DEBRA JUPITER (DAUGHTER)</b>  |   |   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>110 N. PAVSON STREET, BALTIMORE, MD. 21223</b> |  |   |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST</b>   |   |  |  | Date<br><b>4-20-99</b>  |  | 20c. Location - City or Town, State<br><b>OWINGS MILLS, MD.</b>                                |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |  |  |   | 22. Name and Address of Facility<br><b>JOSEPH H. BROWN JR. FUNERAL HOME<br/>2140 N. FULTON AVENUE, BALTO. MD. 21217</b>                            |  |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>7 days</b>  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure</b>   |   |   |  |  |   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |   |   | 28a. Date of Injury (Month, Day, Year) |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how Injury occurred                            |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  | 29b. Signature and title of certifier<br><b>Shelley Snodgrass MD</b>  |  | 29c. License number<br><b>712492</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 13, 1999</b> |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Shelley Snodgrass, MD 10 North Greene Street, Baltimore MD 21201</b>  |  |   |   |  |  |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>  |  | 32. Registrar's Signature<br> |   |  |  |   |  |  |   |  |  |  |  |







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12466

|  |  |   |  |  |   |  |  |   |
|--|--|---|--|--|---|--|--|---|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ROSETTA WILLIE JOHNSON</b>                          |   |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>12</b> Year <b>1999</b> |  | 3. Time of Death<br><b>4:28 pm</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Maryland General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>         |  | 4c. County of Death<br><b>N/A</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>320-20-3070</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 21, 1931</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
|  | Usual Residence of Decedent  |   |  |  | 10c. City, Town or Location   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |
| 10e. Street and Number<br><b>303 N. MONASTERY AVENUE</b>   |  |   |  | 10f. Zip Code<br><b>21229</b>  |   | 10g. Citizen of What Country?<br><b>USA.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>2 yrs</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NURSE</b>  |   | 16b. Kind of Business/Industry<br><b>KEY CIRCLE</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>CLEVELAND JACKSON</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LYDIA WELLS</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>THOMAS JOHNSON JR. (SON)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>303 N. MONASTERY AVE. BALTIMORE, MD. 21229</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LODGE PARK CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>04-17-99 BALTIMORE, MARYLAND</b>   |   | 20d. Date  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><b>JOSEPH H. BROWN JR. FUNERAL HOME<br/>2100 N. FULTON AVE. BALTIMORE, MD. 21217</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |   |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>End Stage Renal Disease</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____  |  |   |  |  |   |  |  |   |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |  |  |   |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |   |
| 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.   |  |   |  | 29c. License number<br><b>89266</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/13/99</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ashraf Mostafa, M.D. 90 Maryland General Hospital</b>   |  |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12467

|   |   |   |  |  |   |  |  |  |  |  |  |  |  |  |
|---|---|---|--|--|---|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EMANUEL KAPLAN</b>   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 12, 1999</b>   |  | 3. Time of Death<br><b>1045 AM</b>                         |  |  |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>#3 STONEHENGE CIRCLE, APT. ONE</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>                    |  |  |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-34-4257</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>89 Yrs.</b>  |  | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 10 1910</b> |  |  |  |  |  |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>            |  |  |  |  |  |  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>#3 STONEHENGE CIRCLE, APT. ONE</b>   |  | 10f. Zip Code<br><b>21208</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |  |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |  |  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PHYSICIAN</b>   |  | 16b. Kind of Business/Industry<br><b>MEDICINE</b>  |   |  |  |  |  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>SAMUEL KAPLAN</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>TOBA CHASSID</b>   |   |  |  |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ELAINE FREEDMAN / DAUGHTER</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1026 ROLANDVUE ROAD RUXTON, MD. 21204</b>  |   |  |  |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH TFILOH CONGREGATION</b>   |  | Date<br><b>4/14/99</b>   |   | 20c. Location - City or Town, State<br><b>WOODLAWN MD</b>                            |  |  |  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS. INC.<br/>8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</b>  |   |  |  |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |  |  |  |  |  |  |  |  |  |
| <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           e. <b>ACUTE MYOCARDIAL INFARCTION</b><br/>           Due to (or as a consequence of):<br/>           b. <b>ASCVD WITH CHRONIC CHF, AF, AR</b><br/>           Due to (or as a consequence of):<br/>           c. <b>COPD</b><br/>           Due to (or as a consequence of):<br/>           d.         </td> <td colspan="6">           Approximate Interval Between Onset and Death<br/> <b>ACUTE</b><br/> <b>15 YEARS</b><br/> <b>20 YEARS</b> </td> </tr> </table> |   |   |  |  |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br>b. <b>ASCVD WITH CHRONIC CHF, AF, AR</b><br>Due to (or as a consequence of):<br>c. <b>COPD</b><br>Due to (or as a consequence of):<br>d. | Approximate Interval Between Onset and Death<br><b>ACUTE</b><br><b>15 YEARS</b><br><b>20 YEARS</b> |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br>b. <b>ASCVD WITH CHRONIC CHF, AF, AR</b><br>Due to (or as a consequence of):<br>c. <b>COPD</b><br>Due to (or as a consequence of):<br>d.  | Approximate Interval Between Onset and Death<br><b>ACUTE</b><br><b>15 YEARS</b><br><b>20 YEARS</b>  |   |  |  |   |  |  |  |  |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |   |  |  |  |  |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |   |  |  |  |  |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |  |  |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>D12405</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/12/99</b>                                |  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHARLES S. ANGELL, M.D. 10755 FALLS RD., STE 200, LUTHERVILLE, MD 21093</b>  |   |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |   | 32. Registrar's Signature<br>   |  |  |   |  |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12468

|   |  |  |   |  |   |  |  |   |  |  |
|---|--|--|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Ellen Kay</i>   |  |   |  | 2. Date of Death<br>Month <i>April</i> Day <i>12</i> Year <i>1999</i>   |  |  |   | 3. Time of Death<br><i>11:55 a.m.</i>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Genesis Eldercare</i>   |  |   |  | 4b. City, Town, or Location of Death<br><i>Randallstown</i>   |  |  |   | 4c. County of Death<br><i>Baltimore, Maryland</i>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>250-50-6705</i>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>87</i> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><i>October 10, 1911</i> |   | 9. Birthplace (State or Foreign Country)<br><i>South Carolina</i>                              |  |
|   | Usual Residence of Decedent  |  |   |  |   |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><i>MD</i>  |  | 10b. County<br><i>BALTIMORE</i>   |  | 10c. City, Town or Location<br><i>RANDALLSTOWN</i>  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><i>9109 Liberty Road</i>   |  |   |  | 10f. Zip Code<br><i>21133</i>   |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>                 |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><i>6th</i>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Housewife</i>   |  |  |   | 16b. Kind of Business/Industry<br><i>own home</i>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>David Harper</i>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Hola Cunningham</i>   |  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Joyce E. Sander</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>6120 Meadow Ave. Woodlawn, 21207</i>  |  |  |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Mt Auburn, Cem.</i>  |  | 20c. Location - City or Town, State<br><i>Balt. Md.</i>   |  |  |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><i>Irvin GARRON 1712 14th W. North Ave, Balt. Md. 21217</i>   |  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><i>UTERINE CANCER</i> |  |   |  |   |  |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                       |  |   |  |   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>GASTRIC CANCER</i>   |  |  |   |  |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |   |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |   |  |   |  |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)  |  |  |   |  |   |  |  |   |  |  |
| 28b. Time of Injury<br>M  |  |  |   |  |   |  |  |   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |  |   |  |  |
| 28d. Describe how injury occurred   |  |  |   |  |   |  |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |   |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Verifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  |   |  |   |  |  |   |  |  |
| 29c. License number<br><i>D20333</i>  |  |  |   |  |   |  |  |   |  |  |
| 29d. Date signed (Month, Day, Year)<br><i>4/14/99</i>   |  |  |   |  |   |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>K. ZONIE MD 1838 ANCESTRY RD PIERCEVILLE</i>   |  |  |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 15 1999</i>   |  |  |   |  |   |  |  |   |  |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



99 12469

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
Item#29d perPhyG770 4/15/99EW

CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>MADISON EDWARD LOWERY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAR 29, 1999</b>  |  |  |  | 3. TIME OF DEATH<br><b>1:00P</b>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-24-7804</b>  |  |  |  | 5. SEX<br><b>1 M 2 F</b>   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>APR 20, 1929</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>6455 Pound Apple Court</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>HOWARD</b>  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>HOWARD</b>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Columbia</b>  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><b>YES 2 NO</b>  |  |  |  | 10e. STREET AND NUMBER<br><b>6455 Pound Apple Court</b>  |  |  |  | 10f. ZIP CODE<br><b>21045</b>   |  |   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |  |  |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>28 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>   |  |   |  |
| 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b>   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  |  |  | 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br><b>8th grade</b>  |  |   |  |
| 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supply Specialist</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dept. of THE Army</b>   |  |  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN Hunter</b>   |  |   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Flossie Lowery</b>   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>JANICE MUSE LOWERY wife</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6455 Pound Apple Ct. Columbia, Md 21045</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Amerson Forest Mt. Cemetery 4/5/99</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>SAWYERS MILLS, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Sparks</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>5240 REISTERSTOWN ROAD BATHING, MD 21215</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → PROSTATE CANCER</b> |  |   |  |
| 24. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |  |  | 25. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN</b> |  |  |  | 26a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>   |  |   |  |
| 26b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b>   |  |  |  | 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined</b>  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |   |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  |  |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>  |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  |   |  |
| 29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29c. SIGNATURE AND TITLE OF CERTIFIER<br><b>W. Salvo</b>   |  |  |  | 29d. LICENSE NUMBER<br><b>D242465</b>   |  |   |  |
| 29e. DATE SIGNED (Month, Day, Year)<br><b>APRIL 1, 1999</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WILLIAM SAWYER, MD 2 KNOL NORTH DR. Columbia MD 21045</b>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>APR 15 1999</b>   |  |   |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Barbara B. Sparks</b>  |  |  |  |  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12470

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES ROSS LAMM

2. Date of Death

Month Day Year

April 11 1999

3. Time of Death

2 P.M.

4a. Facility Name (If not institution, give street and number)

CHURCH HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-05-8710

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 22, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

FL

10b. County

PALM BEACH

10c. City, Town or Location

PALM BEACH

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

27745 S. OCEAN BLVD., #810

10f. Zip Code

33480

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PRESIDENT

18b. Kind of Business/Industry

GLEN EAGLES CLOTHING

17. Father's Name (First, Middle, Last)

JACOB

LAMM

18. Mother's Name (First, Middle, Maiden Surname)

HELEN

DELAVIDE

19a. Informant's Name/Relationship (Type, Print)

CHARLOTTE LAMM (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2774 S. OCEAN BLVD., #810 PALM BEACH, FL 33480

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW

Date

4/14/99

20c. Location - City or Town, State

REISTERSTOWN, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASPIRATION

Due to (or as a consequence of):

c. ALZHEIMER'S DISEASE

Due to (or as a consequence of):

5 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D16619

29d. Date signed (Month, Day, Year)

April 11, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

C. VERGARA-SOAKES 100 N. BROADWAY ST. BALTIMORE MD. 21231

31. Date filed (Month, Day, Year)

APR 15 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

NAME KNOWN TO PHYSICIAN  
Baltimore, Maryland 21215-0020

Permit - Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, 92  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12471

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>SYLVIA</b>   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 14, 1999</b>   |   | 3. Time of Death<br><b>1:45 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>MILFORD MANOR NURSING HOME</b>   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>                  |
| 5. Social Security Number<br><b>024-09-1943</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 15, 1914</b>   | 9. Birthplace (State or Foreign Country)<br><b>MASS.</b> |
| Usual Residence of Decedent   |  |   |   |   |  |
| 10a. State<br><b>MASS</b>   |  | 10b. County<br><b>MIDDLESEX</b>   |   | 10c. City, Town or Location<br><b>NEWTON CENTER</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |   |  |
| 10e. Street and Number<br><b>31 MORSELAND AVENUE</b>  |  |   | 10f. Zip Code<br><b>02459</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>           |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (14 or 5+) <b>Collega</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALES</b>   |   | 16b. Kind of Business/Industry<br><b>RETAIL</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>BENJAMIN BEARSE</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JENNIE COHEN</b>  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SANDY VOGEL / DAUGHTER</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6603 LINCO AVENUE - BALTIMORE, MD 21209</b> |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH EL CEMETERY</b>   |   | 20c. Location - City or Town, State<br><b>4/14/99 WEST ROXBURY, MASS.</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Scott M. Cutler</i>   |  |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>               |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Cardiomyopathy</i><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |   |  |
| 29b. Signature and title of certifier<br><i>Raymond Muller MD</i>   |  | 29c. License number<br><b>D47683</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/14/99</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Raymond Muller 25 Main Street Suite 200 Reisterstown MD</i>  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |   |   |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



99-1950-510

jhm

THOMAS N

PARKS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, PER MEO G770 4-30-99 WR. **Certificate of Death**

Reg. No.

99 12472

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas N. Parks

2. Date of Death

APRIL 03, 1999

3. Time of Death

09:09 AM

4a. Facility Name (If not institution, give street and number)

2443 MAISEL COURT

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

339-44-7051

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 6, 1950

9. Birthplace (State or Foreign Country)

ILLINOIS

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Westport

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2443 Maisel Ct.

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Crane Operator

16b. Kind of Business/Industry

Pac Construction

17. Father's Name (First, Middle, Last)

Floyd Parks

18. Mother's Name (First, Middle, Maiden Surname)

Shirley Beard

19a. Informant's Name/Relationship (Type, Print)

Mrs. Anna Parks (wife)

19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code)

2443 Maisel Ct. Balto., Md. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

4/20/99

20c. Location - City or Town, State

Owings Mills, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto., Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Monte Don Yonke

29c. License number

OCME

29d. Date signed (Month, Day, Year)

APRIL 04, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Ann P. Konec

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

APR 15 1999

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |  |   |  |  |   |   |   |  |  |  |  |   |  |
|---|--|---|--|--|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LIONEL Porter</b>   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 12 1999</b>    |   | 3. Time of Death<br><b>1802</b>                           |  |  |  |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland Medical Center-Baltimore, MD</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b> |   | 4c. County of Death<br><b>Baltimore</b>                   |  |  |  |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-48-1653</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.              |   | 8. Date of Birth<br>Month Day Year<br><b>May 25, 1948</b> |  |  |  |  |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>                               |   | 10c. City, Town or Location<br><b>Randallstown</b>        |  |  |  |  |   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3618 Annehathaway Dr.</b>  |  | 10f. Zip Code<br><b>21133</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |  |  |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>African American</b>       |   |  |  |  |  |   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>   |  | 16b. Kind of Business/Industry<br><b>Private Industry</b>  |   |   |   |  |  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Sheneverius C. Porter</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bernice V. Bennett</b>   |   |   |   |  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Timothy Porter (Brother)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>327 W. 84<sup>th</sup> St. New York, N.Y. 10024</b>                                      |   |   |   |  |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Alphonsus Cem.</b>   |  | 20c. Location - City or Town, State<br><b>4/17/99 Granite, Md.</b>   |   |   |   |  |  |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>  |  |   |  | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto, Md. 21216</b>   |   |   |   |  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. sepsis</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |   |  |  |   |   |   | Approximate Interval Between Onset and Death   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>pneumonia</b><br><b>AIDS</b>   |  |   |  |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |   |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |   |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |   |   |   | 29b. Signature and title of certifier<br><b>W. Russ MD</b>   |  | 29c. License number<br><b>P10356</b>                 |  | 29d. Date signed (Month, Day, Year)<br><b>April 12 1999</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>University of Maryland Medical Center 22 South Greene St. Baltimore, MD</b>  |  |   |  |  |   |   |   | 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>  |  | 32. Registrar's Signature<br><b>Benita B. Sparks</b> |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12474

|   |  |   |  |  |  |   |   |  |
|---|--|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL GERALD RANDOLPH, SR</b>                       |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APR 8 1999</b>  |   | 3. Time of Death<br><b>1550</b>                             |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital of Baltimore</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b> |   | 4c. County of Death<br><b>N/A</b>                           |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>UNKNOWN</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.         |   | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 13, 1958</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>                                |   | 10c. City, Town or Location<br><b>BALTIMORE</b>             |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>2771 W. North Ave</b>  |  | 10f. Zip Code<br><b>21216</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12th grade</b>   |  | College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MECHANIC</b>   |  | 16b. Kind of Business/Industry<br><b>Auto Body Shop</b>                                     |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>MATTHEW RANDOLPH</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HELEN FRANCES HARDY</b>  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>REV. Phyllis McCleod / Brother</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3907 FAIRFAX ROAD BALTIMORE, MD 21216</b>  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>Brooklyn, MD</b>   |  | 20d. Date<br><b>4-14-99</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Greg Harris</b>   |  |   |  | 22. Name and Address of Facility<br><b>CHATHAM - HARRIS F.H. 5240 KEISTERSTOWN ROAD BALTIMORE, MD 21215</b>  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>INTRACRANIAL HEMORRHAGE</b><br>Due to (or as a consequence of):<br><br>b. <b>COCAINE, HEROIN TOXICITY</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>4-7-99</b>  |  | 28b. Time of Injury<br><b>UNK</b> M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred<br><b>UNKNOWN</b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>371 Calhoun St, Balto. 21211</b>  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |   |  |
| 29b. Signature and Title of Certifier<br><b>[Signature] MD</b>  |  |   |  | 29c. License number<br><b>P12340</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-13-99</b>                                       |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>OSTERMAN, MD SINAI HOSPITAL OF BALTIMORE, 2401 W. BALTIMORE, BALTIMORE, MD 21215</b>   |  |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12475

|  |  |   |  |   |   |  |                                 |  |   |  |
|--|--|---|--|---|---|--|---------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ELINOR NORRIS SEIDL</b>                     |   |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 14, 1999</b> |  |                                 |  | 3. Time of Death<br><b>4:40AM</b>             |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>7312 ALVAH AVENUE</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>DUNDALK</b>      |  |                                 |  | 4c. County of Death<br><b>BALTIMORE</b>       |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-12-9449</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.            |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.                |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 18, 1913</b>                                |   | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>                         |   | 10a. State<br><b>MD.</b>                                    |  | 10b. County<br><b>BALTIMORE</b> |  | 10c. City, Town or Location<br><b>DUNDALK</b> |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>7312 ALVAH AVENUE</b>  |   | 10f. Zip Code<br><b>21222</b>  |                                 | 10g. Citizen of What Country?<br><b>U.S.A.</b>                         |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                         |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |                                 |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BINDER WORKER</b>   |  | 16b. Kind of Business/Industry<br><b>FACORY</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>CLARENCE WEST</b>  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CAATHERINE</b> |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>WILLIAM NORRIS/SON</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9065 TUSING AVE. MECHANICSVILLE, VIRGINIA 23116</b>   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OAK LAWN CEMETERY</b>   |                                 | Date<br><b>4/16/99</b>   |   | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>                    |
| 21. Signature of Funeral Service Licensee<br><i>Elizabeth Selinski</i>   |  | 22. Name and Address of Facility<br><b>CHARLES S. ZEILER &amp; SON, INC.</b><br><b>6224 EASTERN AVE. BALTIMORE, MD. 21224</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>arrhythmia</b><br>Due to (or as a consequence of):<br><br>b. <b>congestive heart failure</b><br>Due to (or as a consequence of):<br><br>c. <b>renal insufficiency</b><br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death<br><br><b>minutes</b><br><br><b>48hrs</b><br><br><b>YRS</b>   |                                 |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>gluten-sensitive enteropathy</b><br><b>nephrolithiasis</b><br><b>hypertension</b> |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                 |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |                                 | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                 |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>D 46289</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 15, 1999</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BEILINDA M CHEN 2112 DUNDALK AVE, BALTO, MD 21222</b>   |                                 |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |   |  |                                 |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



99 12476

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mildred Schuster</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Apr. 10, 99</b>  |  | 3. TIME OF DEATH<br><b>4:30 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-44-3861</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 24, 1912</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Augsburg Lutheran Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore/Lochern</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1918 Maxwell Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21222</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (8-12) <b>9</b> College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Fed. Govertment</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edgar Lyter</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gabrielle Holland</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Gabriella Holland/ Niece</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>243 S. East Ave., Balto., Md. 21224</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Park 4-14-99 Elkridge, Md</b>         |  | DATE<br><b>4-14-99</b>  |  | 20c. LOCATION — City or Town, State<br><b>Elkridge, Md</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bradley-Ashton-Matthews Funeral Home Inc.<br/>2134 Willow Spring Rd., Balto., Md. 21222</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. GASTRIC CARCINOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate interval Between Onset and Death<br><b>2 MONTHS</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>H45931</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 11, 1999</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DEBORAH I. PIERCE 7220 PARK HEIGHTS AVENUE BALTIMORE MD</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 15 1999</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12477

|   |  |   |  |  |  |  |   |  |
|---|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Edith Sause</b>                               |   |  |  | 2. Date of Death<br>Month Day Year<br><b>Apr. 10, 1999</b> |  | 3. Time of Death<br><b>8:50 P.M.</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Cromwell Elder Care</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>      |  | 4c. County of Death<br><b>Baltimore</b>                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-16-8624</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                             | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 9, 1922</b>  | 9. Birthplace (State or Foreign Country)<br><b>Balto. Md.</b> |  |
|   | Usual Residence of Decedent  |   |  |  |  |  |   |  |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>5106 Harford Rd.</b>   |  |   |  | 10f. Zip Code<br><b>21214</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>College</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Kratz</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Chnitker</b>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Melvin Pryor</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Suite 1207, 28 Alleghany Ave., Towson, Md. 21204</b>                                     |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Balto-Wash. Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Laurel, Md.</b>  |  | 20d. Date<br><b>4-14-99</b>  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222</b>  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Congestive heart failure</b><br>Due to (or as a consequence of):<br>b. <b>Respiratory failure</b><br>Due to (or as a consequence of):<br>c. <b>Right breast carcinoma</b><br>Due to (or as a consequence of):<br>d. <b>Cardiomyopathy</b> |  |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Degenerative Joint Disease</b><br><b>Hypertension</b><br><b>myocardial infarction</b>  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br>MD   |  | 29c. License number<br><b>D 31464</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/13/99</b>  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHOA 113 A. HASTON, 821 N. EUTAW St Suite 308 Balt. MD 21201</b>   |  |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>   |  | 32. Registrar's Signature<br>   |  |  |  |  |   |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12478

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

LEROY STEWART SMITH

2. Date of Death

Month Day Year  
APRIL 13, 1999

3. Time of Death

12:20 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GILCHRIST HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

220-36-7021

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 27, 1942

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedant

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5112 LEVINDALE ROAD

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

BGE

17. Father's Name (First, Middle, Last)

LEROY SMITH

18. Mother's Name (First, Middle, Maiden Summa)

DOROTHY MILLER

19a. Informant's Name/Relationship (Type, Print)

CAROLYN SMITH (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5112 LEVINDALE ROAD, BALTIMORE, MARYLAND 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

04-17-99

20c. Location - City or Town, State

WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE., BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Small cell lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25205

29d. Date signed (Month, Day, Year)

April 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley G.B.M.C. 6701 N. Charles St. Balto. md

31. Date filed (Month, Day, Year)

APR 15 1999

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12479

|   |   |   |  |   |  |  |  |  |  |  |  |
|---|---|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Tracy M. Statler                        |   |  |   | 2. Date of Death<br>Month Day Year<br>APRIL 13, 1999 |  | 3. Time of Death<br>2:17 PM.   |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>SUBURBAN HOSPITAL |   |  |   | 4b. City, Town, or Location of Death<br>BETHESDA     |  | 4c. County of Death<br>Montgomery  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>195-60-6942  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>30 Yrs.   | If Under 1 Year<br>Months Days                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>November 9, 1968  |  | 9. Birthplace (State or Foreign Country)<br>PA |  |  |
|   | Usual Residence of Decedent   |   |  |   |  |  |  |  |  |  |  |
| 10a. State<br>MD  |   | 10b. County   |  | 10c. City, Town or Location<br>Germantown   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br>1155 Summer Oak Drive   |   |   |  | 10f. Zip Code<br>11555  |  | 10g. Citizen of What Country?<br>United States                                       |  |  |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White  |  |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0  |   |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working<br>life. DO NOT use retired)<br>Clerk  |  |  | 16b. Kind of Business/Industry<br>Flooring Co.   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>George Statler   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Wolfhope   |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>George W. Statler /Father   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1155 Summer Oak Drive, Germantown MD 11555   |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of<br>cemetery, crematory or other place)<br>Grandview Cemetery   |  | Date U.N.K. April 1999  |  | 20c. Location - City or Town, State<br>Johnstown, PA                                 |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Victor P. Doda, Jr.<br>[Signature]   |   |   |  | 22. Name and Address of Facility<br>Charles L. Stevens Funeral Home, Inc.<br>1501 E. Fort Avenue, Baltimore Maryland 21230  |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,<br>shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CARDIAC ARRYTHMIA ASSOCIATED WITH MILD LEFT VENTRICULAR DILATATION<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |  |
|   |   |   |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |
|   |   |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>Theodore M. Higgins  |   |   |  | 29c. License number<br>O.C.M.E.   |  | 29d. Date signed (Month, Day, Year)<br>APRIL 14, 1999                                |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>THEODORE M. HIGGINS 111 Penn Street, Baltimore, Maryland 21201  |   |   |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 15 1999  |   | 32. Registrar's Signature<br>[Signature]  |  |   |  |  |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Item#8 perFHG770 4/15/99 EW

99 12480

|  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ANNE S SPECTOR   |  |   |  | 2. Date of Death<br>APRIL 12 1999  |  |  |  | 3. Time of Death<br>7:10PM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>NORTH OAKS HEALTH CENTER   |  |   |  | 4b. City, Town, or Location of Death<br>PIKESVILLE   |  |  |  | 4c. County of Death<br>BALTIMORE   |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-28-0290   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>89 Yrs.  |  | 8. Date of Birth<br>3-19-1910  |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD   |  | 10b. County<br>BALTIMORE  |  | 10c. City, Town or Location<br>PIKESVILLE  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>725 MOUNT WILSON LANE  |  |   |  | 10f. Zip Code<br>21208   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER  |  |  |  | 16b. Kind of Business/Industry<br>OWN HOME   |  |  |  |
| To Be Completed by Physician/Medical Examiner                                | 17. Father's Name (First, Middle, Last)<br>MEYER SUMERS  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>LILLIE WAGMAN   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>LIBBY BERMAN/ DAUGHTER   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>29 RAISIN TREE CIRCLE PIKESVILLE, MD. 21208   |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>BETH TFILOH CONGREGATION  |  | 20c. Date<br>4/14/99   |  | 20d. Location - City or Town, State<br>WOODLAWN MD.                                  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Jay Alan Lewis  |  |   |  | 22. Name and Address of Facility<br>SOL LEVINSON & BROS. INC.<br>8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. DEMENTIA<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>YRS  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |  |  |
| State<br>Registrar   | 29b. Signature and title of certifier<br>K. ZOMIES MD  |  |   |  | 29c. License number<br>D20333  |  | 29d. Date signed (Month, Day, Year)<br>4/13/99                                       |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br>K. ZOMIES MD 836 CENTREE RD PIKESVILLE MD  |  |   |  |  |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>APR 14 1999   |  |   |  | 32. Registrar's Signature<br>B. Spauls   |  |  |  |  |  |

ORIGINAL





99 12481

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be enclosed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|  |  |  |  |   |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>male Sykes</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>15</i> YEAR <i>99</i>   |  | 3. TIME OF DEATH<br><i>7:43 P. M.</i>   |  |   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>NONE</i>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><i>1 1 1</i> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>MAR. 14, 1999</i>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>MARYLAND</i>   |  |   |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>PRINCE GEORGES HOSPITAL CENTER</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>CHEVERLY</i>  |  | 9c. COUNTY OF DEATH<br><i>PRINCE GEORGES</i>  |  |   |  |  |  |   |  |
| 10a. STATE<br><i>MARYLAND</i>  |  | 10b. COUNTY<br><i>PRINCE GEORGES</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>RIVERDALE</i>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><i>6002 GREENVALE PARKWAY</i>  |  |  |  | 10f. ZIP CODE<br><i>20781</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |   |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>BLACK</i>                             |  |   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (5-12) <i>INFANT</i><br>College (1-4 or 5+) <i>INFANT</i>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>INFANT</i>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><i>INFANT</i>   |  |   |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>UNKNOWN</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>EURIDICE SYKES</i>  |  |   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>PRINCE GEORGES HOSPITAL CENTER</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3001 HOSPITAL DRIVE, CHEVERLY, MD 20785</i>   |  |   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>PRINC 32009</i>  |  | 20c. LOCATION — City or Town, State<br><i>Chesley, Md</i>   |  | 20d. DATE<br><i>3/16/99</i>   |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>PRINC Chesley, Md 20785</i>  |  |   |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. prematurity</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  | 29c. LICENSE NUMBER<br><i>D13625</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/16/99</i> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><i>JONG CEE, MD - 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785</i>  |  |  |  |   |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 15 1999</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |   |  |  |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12482

|   |   |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |
|---|---|--|---|--|--|---|--|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Dolores G. Williams   |  |   |  |  | 2. Date of Death<br>Month Day Year<br>April 13, 1999  |  | 3. Time of Death<br>8:00 A.M.  |  |  |  |  |  |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>713 Seagrove Road   |  |   |  |  | 4b. City, Town, or Location of Death<br>Glen Burnie   |  | 4c. County of Death<br>Anne Arundel  |  |  |  |  |  |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>279-26-9475  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>68 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Aug. 7, 1930                                  |  | 9. Birthplace (State or Foreign Country)<br>Ohio |  |  |  |  |  |   |  |
|   | Usual Residence of Decedent   |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Glen Burnie   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |  |  |  |   |  |
|   | 10e. Street and Number<br>713 Seagrove Road   |  |   |  | 10f. Zip Code<br>21060   |   | 10g. Citizen of What Country?<br>United States                                       |  |  |  |  |  |  |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |  |  |  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |  |   | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |  |  |  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)   |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Viola  |  |  |  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Penny L. O'Neill/Daughter   |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1250 Vintage Drive Harwood, MD 20776 |  |  |  |  |  |  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Cemetery  |  | 20c. Date<br>April 16, 1999  |   | 20d. Location - City or Town, State<br>Brentwood, Maryland                           |  |  |  |  |  |  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  |  | 22. Name and Address of Facility<br>Kirkley-Ruddick Funeral Home<br>421 Crain Hwy. S.E. Glen Burnie MD 21061                          |  |  |  |  |  |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Sepsis Due to (or as a consequence of):<br>b. Gangrene of foot Due to (or as a consequence of):<br>c. Diabetes mellitus Due to (or as a consequence of):<br>d. CAD<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br>2 mos<br>2 mos   |  |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |  |  |  |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                |  |  |  |  |  |   |  |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |  |  |  |  |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |  |  |  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br>D51304          |  | 29d. Date signed (Month, Day, Year)<br>April 15, 1999 |  |
|   | 30. Name and address of person who completed cause of death (28a) (Type, Print)<br>Kimbrough - Army Hospital Ft. Meade Md. 20755  |  |   |  |  |   |  |  |  |  | 31. Data filed (Month, Day, Year)<br>APR 15 1999   |  | 32. Registrar's Signature<br>B. Sparks |  |   |  |

838-60-8888  
CANCER MEDICINE SERVICE  
BMT, BIC, OSA  
NOON MON, WED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12483

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JANET VIRGINIA CARTER WASHINGTON

2. Date of Death

APRIL

14

1999

3. Time of Death

2:09 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-36-7139

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 30, 1942

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1010 W. BALTIMORE ST. APT 221

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11TH GRADE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOHNIE

BROWN SR.

18. Mother's Name (First, Middle, Maiden Surname)

IRENE

WARNER

19a. Informant's Name/Relationship (Type, Print)

SHARON CARTER (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3016 WOODLAND AVE., BALTIMORE, MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

04-20-99 OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE., BALTO., MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. EMPYEMA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 hr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DU051965

29d. Date signed (Month, Day, Year)

APRIL 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES CURTIS ST AGNES HOSPITAL BALTIMORE

31. Date filed (Month, Day, Year)

APR 15 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                                |   |  | 99 12484  |  |   |  |
|--|--|--|--|---|--------------------------------|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |                                |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>male Wooten</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>MAR. 16, 1999</i>  |                                | 3. TIME OF DEATH<br><i>6:30 A. M.</i>   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>NONE</i>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>MAR. 16, 1999</i>                                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>MARYLAND</i>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>PRINCE GEORGES HOSPITAL CENTER</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>CHEVERLY</i>  |                                | 9c. COUNTY OF DEATH<br><i>PRINCE GEORGES</i>  |  |   |  |   |  |
| 10a. STATE<br><i>MARYLAND</i>  |  | 10b. COUNTY<br><i>PRINCE GEORGES</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>CAPITOL HEIGHTS</i>   |                                | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><i>1214 BROOK ROAD</i>   |  |  |  | 10f. ZIP CODE<br><i>20743</i>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>BLACK</i>                             |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>INFANT</i><br>College (14 or 5+) <i>INFANT</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>INFANT</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>INFANT/NONE</i>  |                                |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>UNKNOWN</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>LAVERNE D. WOOTEN</i>   |                                |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>PRINCE GEORGES HOSPITAL CTR.</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3001 HOSPITAL DRIVE, CHEVERLY, MD 20705</i>   |                                |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other <i>3001 HOSP</i>   |  | 20b. PLACE AND DATE OF DISPOSITION (In case of cremation, crematory or other place)<br><i>PRINCE GEORGES CHURCH, MD</i>  |  |   |                                |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>PRINCE CHURCH, MD</i>  |                                |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Extreme Prematurity</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |                                |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |                                |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |                                |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |                                |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jeannette E. Akuter MD</i>   |  |  |  |   |                                | 29c. LICENSE NUMBER<br><i>D40377</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3-16-99</i>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Jeannette E Akuter MD Prince Georges Hosp Ctr, Cheverly, MD</i>  |  |  |  |   |                                |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 15 1999</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |                                |   |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 5 Per FH FilmG770 4-20-99 r

State of Maryland / Department of Health and Mental Hygiene

99 12485

Amended#23apt1D PERPhyG770 4/15/99 EW

Certificate of Death

Reg. No.

|  |   |  |   |   |  |                                      |   |  |  |   |  |   |  |
|--|---|--|---|---|--|--------------------------------------|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Gilbert K. Young</b>   |  |   |   |  |                                      | 2. Date of Death<br>Month Day Year<br><b>April 2, 1999</b>  |  |  | 3. Time of Death<br><b>11:05p.m.</b>  |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3710 Harlem Avenue</b>   |  |   |   |  |                                      | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |  | 4c. County of Death<br><b>n/a</b>   |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-32-2629</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.   |                                      | If Under 1 Year<br>Months Days  |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 29, 1935</b>                                    |   | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>   |   |  |
|  | Usual Residence of Decedent   |  |   |   |  |                                      |   |  |  |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |                                      |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |   |  |
|  | 10e. Street and Number<br><b>3710 Harlem Avenue</b>   |  |   |   | 10f. Zip Code<br><b>21229</b>  |                                      |   | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |   |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                      |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>          |  |   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th grade</b> College (1-4or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Millwright</b>   |                                      |   |  | 16b. Kind of Business/Industry<br><b>Bethlehem Steel</b>                                       |   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Abraham Young</b>   |  |   |   |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louise Kent</b>   |  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Greta A. Young</b>   |  |   |   |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3710 Harlem Ave. Baltimore, MD. 21229</b> |  |  |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |                                      | Date<br><b>April 9</b>  |  | 20c. Location - City or Town, State<br><b>Brooklyn, MD.</b>                                    |   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Ernest R. Young, Jr.</b>  |  |   |   |  |                                      | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls Pkwy Baltimore, MD. 21216</b>                         |  |  |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>LIVER FAILURE</b><br>Due to (or as a consequence of):<br><b>METASTATIC LUNG CANCER</b><br>Due to (or as a consequence of):<br><b>L.U.L. ASCLE</b><br>Due to (or as a consequence of):<br><b>LEFT UPPER LOBE NON SMALL CELL LUNG CANCER</b> |  |   |   |  |                                      |   |  |  |   | Approximate Interval Between Onset and Death<br><b>2 W</b><br><b>1 M</b><br><b>1 Y</b>   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |                                      |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |   |  |   |   |  |                                      |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                      |   |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>      |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |   |  |
|  |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                      |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |   |  |   |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |                                      |   |  |  |   |  |   |  |
| 29b. Signature and Title of certifier<br><b>Dr. Petr Hausner</b>   |   |  |   |   |  | 29c. License number<br><b>D48160</b> |   | 29d. Date signed (Month, Day, Year)<br><b>4/5/99</b>                             |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PETR HAUSNER, 22 South Greene Street, Baltimore, Md 21201</b>   |   |  |   |   |  |                                      |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1999</b>  |   |  |   | 32. Registrar's Signature<br><b>Laura B. Sparks</b>   |  |                                      |   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760



W 2  
M 4  
Y 1

FOR THE  
HISTORICAL  
SOCIETY

X

X

THE  
HISTORICAL  
SOCIETY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12486

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Vivian Irving Akers

2. Date of Death  
Month Day Year

April 14 1999

3. Time of Death

8:00A.M.

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

231-30-9320

6. Sex

M 2 F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 25, 1927

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1057 Minnetonka Road

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: 1946-47

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Irving Akers

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Morehead

19a. Informant's Name/Relationship (Type, Print)

Frances J. Akers (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1057 Minnetonka Road, Severn, MD 21144

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem.

Date

04/16

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

Patricia J. Akers

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF THE LUNGS

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patricia J. Akers

M.D.

29c. License number

D43977

29d. Date signed (Month, Day, Year)

April 14 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Choren Oretuniji. 301 Hospital Drive Glen Burnie. MD. 21061.

31. Date filed (Month, Day, Year)

APR 16 1999

32. Registrar's Signature

B. Akers

State  
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

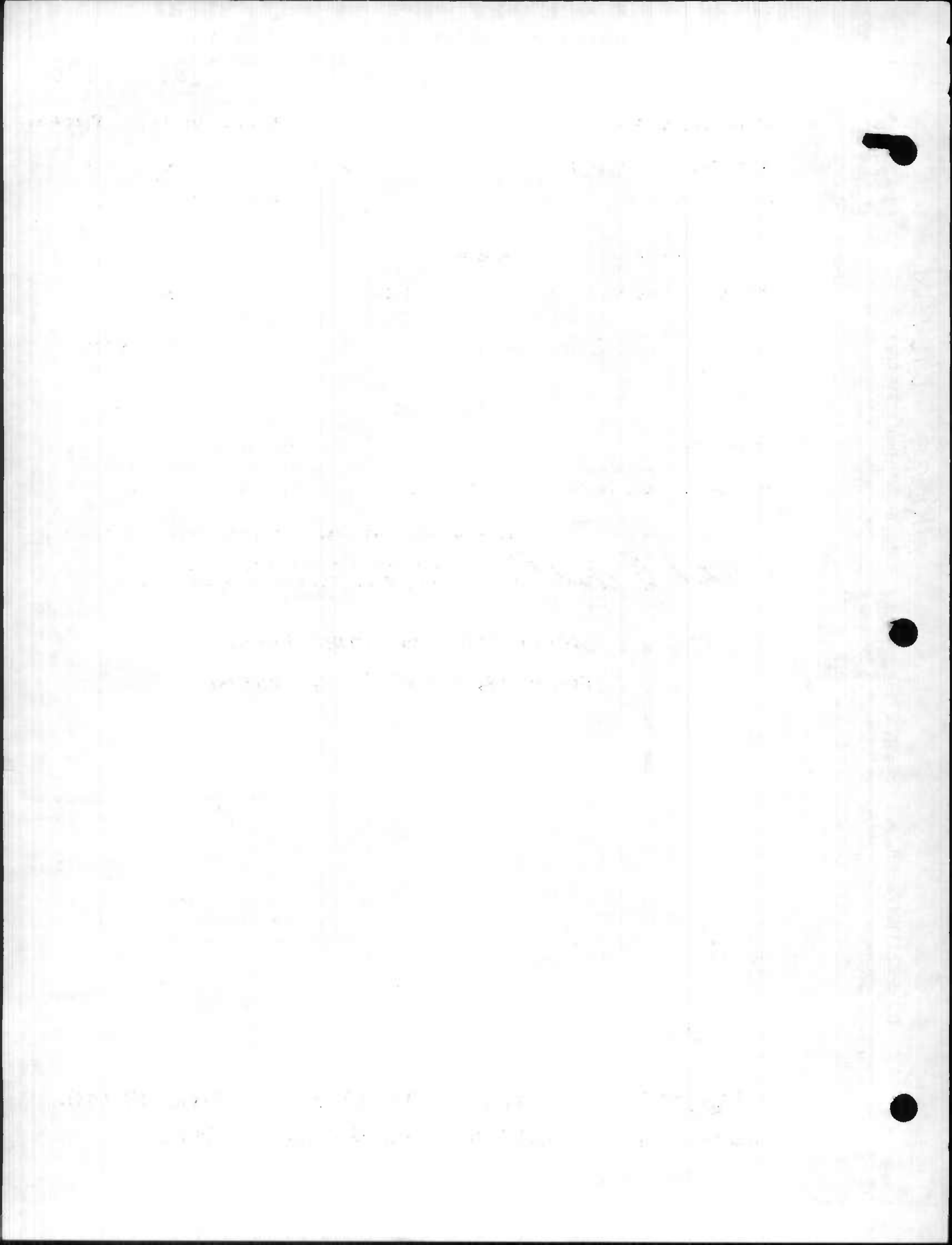
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

AKERS, VIVIAN

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12487

|  |   |   |   |   |  |   |  |  |  |  |  |
|--|---|---|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Rodney Gene Austin                                    |   |   |   | 2. Date of Death<br>Month Day Year<br>April 13, 1999 |   |  |  | 3. Time of Death<br>2:10 A.M.          |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Prince George's Hospital Center |   |   |   | 4b. City, Town, or Location of Death<br>Cheverly     |   |  |  | 4c. County of Death<br>Prince George's |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-92-2525  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>36 Yrs. | 8. Date of Birth (Month, Day, Year)<br>12 31 1962   |  | 9. Birthplace (State or Foreign Country)<br>Md  |  |  |  |  |  |
|  | Usual Residence of Decedent   |   |   |   |  |   |  |  |  |  |  |
| 10a. State<br>Md   |   | 10b. County<br>NA   |   | 10c. City, Town or Location<br>Baltimore  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br>3627 Columbus Drive  |   |   |   | 10f. Zip Code<br>21215  |  | 10g. Citizen of What Country?<br>U S A  |  |  |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th grade<br>College (1-4 or 5+) 3 Years   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Chef   |  |   | 16b. Kind of Business/Industry<br>Arlington Hilton Hotel         |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Richard P Austin  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Florence H. Scott  |  |   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Florence Austin - Mother   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3627 Columbus Drive Baltimore, Md 21215  |  |   |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery   |  | Date<br>4-17-99   |  | 20c. Location - City or Town, State<br>Woodlawn, Md  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Gabrielle Cook  |   |   |   | 22. Name and Address of Facility<br>March F/H West<br>4300 Wabash Avenue Baltimore, Md 21215  |  |   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Gunshot Wound of Right Chest<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |   |   |   |   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  |   |   |   |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)<br>4/13/99   |   | 28b. Time of Injury<br>1304 M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br>subject shot  |  |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>street  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Scupper Ave + Rail St<br>Washington, D.C.   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |   |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>Dennis J. Chute, MD   |   |   |   | 29c. License number<br>O.C.M.E.   |  |   |  | 29d. Date signed (Month, Day, Year)<br>April 13, 1999  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201   |   |   |   |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 16 1999   |   |   |   | 32. Registrar's Signature<br>B. Sparks  |  |   |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12488

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth M. Budzik

2. Date of Death

Month Day Year  
APRIL 15 1999

3. Time of Death

1:05 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

219-01-3262

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 15, 1920

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7131 Railway Ave.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8 yrs.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

George Mox

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Dorbert

19a. Informant's Name/Relationship (Type, Print)

Barbara Douglass daughter 7929 Severn Tree Blvd. Severn Md. 21144

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Mary 4-19

Date

20c. Location - City or Town, State

Dundalk

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Connolly Funeral Home Of Dundalk  
7110 Sollers Point Rd. 21222

23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic shock  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease  
Due to (or as a consequence of):

years

c. \_\_\_\_\_  
Due to (or as a consequence of):

d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

022483

29d. Date signed (Month, Day, Year)

April 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STUART JACOB MD 200 Hospital Dr. Suite 409 Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

APR 16 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

THE UNIVERSITY OF CHICAGO

LIBRARY

1950

1951

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State of Maryland / Department of Health and Mental Hygiene **99 12489**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **MABEL T BOSWELL** 2. Date of Death Month **04** Day **14** Year **99** 3. Time of Death **01.42**

4a. Facility Name (If not institution, give street and number) **Church Hospital** 4b. City, Town, or Location of Death **Balto. Md** 4c. County of Death **N. A**

5. Social Security Number **217 22 6243** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **77** Yrs. 8. Date of Birth (Month, Day, Year) **1-23-22** 9. Birthplace (State or Foreign Country) **Md**

Usual Residence of Decedent

10a. State **Md** 10b. County **N. A** 10c. City, Town or Location **Balto** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **221 Silver Ct.** 10f. Zip Code **21223** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **Black**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **9th** College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry **Self**

17. Father's Name (First, Middle, Last) **Emogene Butler** 18. Mother's Name (First, Middle, Maiden Surname) **Maggie James**

19a. Informant's Name/Relationship (Type, Print) **Roby Boswell SON** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **221 N. Silver Ct Balto Md 21223**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Voshehl Mem Park** Date **4/20/99** 20c. Location - City or Town, State **Balto. Md**

21. Signature of Funeral Service Licensee **Joseph G. Locks Jr** 22. Name and Address of Facility **Joseph G. Locks Jr 741304 N. Central Ave**

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) **ANOXIC ENCEPHALOPATHY** Approximate Interval Between Onset and Death **5 days**  
 Due to (or as a consequence of): **STATUS EPILEPTICUS** **5 days**  
 Due to (or as a consequence of): **CARDIAL ARREST** **7 days**  
 Due to (or as a consequence of): **RENAL INSUFFICIENCY** **months**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No

26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Ryszard Skulski, M.D.** 29c. License number **D0053296** 29d. Date signed (Month, Day, Year) **04/14/99**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **RYSZARD SKULSKI, M.D. CHURCH HOSPITAL, BALTIMORE, MARYLAND**

31. Date filed (Month, Day, Year) **APR 16 1999** 32. Registrar's Signature **B. Sparks**

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-0000.



W. J. Locke Jr  
Joseph C. Locks Jr  
Voselet M. W. Brown  
204 251 N. 1st St. Bx 111  
The



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #20B PER F.H. G770 4-26-99 WR.

## Certificate of Death

Reg. No.

99 12490

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

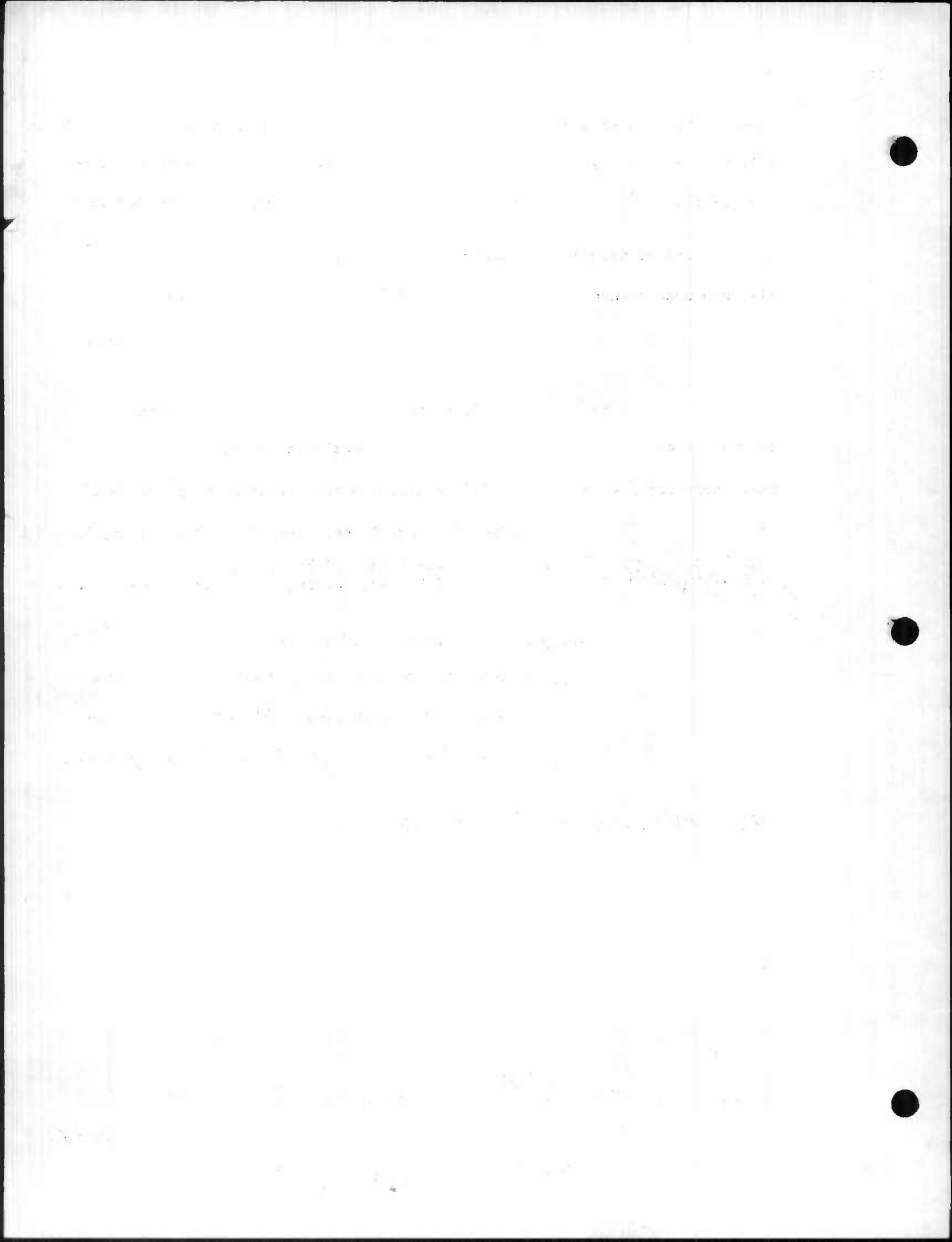
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |  |   |   |  |  |
|---|--|---|--|--|--|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Bernard Niel Bertrand</b>  |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>April 11, 1999</b>  |  |   | 3. Time of Death<br><b>11:30 a.m.</b>                 |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>1110 Montrose Avenue</b>   |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>  |  |   | 4c. County of Death<br><b>Prince George</b>           |  |  |
| 5. Social Security Number<br><b>073-01-0524</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.  |   | 8. Date of Birth (Month, Day, Year)<br><b>April 23, 1916</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  |   |  |  |  |  |  |   |   |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |   |   |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince George</b>   |  | 10c. City, Town or Location<br><b>Laurel</b>   |  |  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1110 Montrose Avenue</b>   |  |   |  | 10f. Zip Code<br><b>20707</b>  |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>5+</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Inspector</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Health</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Berman</b>   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Rosenstein</b>  |  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Bertrand / Wife</b>  |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1110 Montrose Avenue, Laurel, Maryland 20707</b> |  |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Whitesville Rural Cem.</b>  |  | Date<br><b>4-16-99</b><br><b>4/15/99</b>   |  | 20c. Location - City or Town, State<br><b>Whitesville, New York</b>                         |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  |  |  | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.</b><br><b>7601 Sandy Spring Road, Laurel, Maryland 20707</b>                         |  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. <b>CONGESTIVE HEART FAILURE</b><br/>Due to (or as a consequence of):</p> <p>b. <b>CORONARY ARTERY DISEASE</b><br/>Due to (or as a consequence of):</p> <p>c. <b>ISCHEMIC CARDIOMYOPATHY</b><br/>Due to (or as a consequence of):</p> <p>d. <b>CORONARY ARTERY BYPASS GRAFT SURGERY 1998</b></p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>DAYS</b></p> <p><b>MORE THAN 5 YEARS</b></p> <p><b>"</b></p> </div> </div> |  |   |  |  |  |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>VENTRICULAR ARRHYTHMIAS</b>  |  |   |  |  |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Anees Amin M.D.</b>   |  |   |  |  |  | 29c. License number<br><b>D0036192</b>   |  |   | 29d. Date signed (Month, Day, Year)<br><b>4-12-99</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>7610 CARROLL AVE Ste # 380 TAKOMA PARK, MD 20912</b>   |  |   |  |  |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 16 1999</b>   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |   |   |  |  |



cm  
Michael Bogdan

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12491

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael Bogdan

2. Date of Death  
Month Day Year

March 28, 1999

3. Time of Death

12:10 P.M.

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center, SICU

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-98-6448

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

34

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 17, 1964

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

437 Bonsal Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Plumber's Assistant

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

Walter Bogdan

18. Mother's Name (First, Middle, Maiden Surname)

Joan Mary Snyder

19a. Informant's Name/Relationship (Type, Print)

Regina Scales

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

600 Fox Bow, Bel Air, Maryland 21014

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Baltimore Washington Cr.

Date

4/5/99

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Gunshot wound to the head

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?Inspection  
☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☒ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

03-27-99

28b. Time of Injury

A M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Subject shot self.

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

A park on hospital property.

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)5600 block Mason  
Lord Dr., Baltimore, MD29a. Certifier  
(Check only one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

3/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12492

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Virginia Benson

2. Date of Death

April 13 1999

3. Time of Death

4:40AM

4e. Facility Name (If not Institution, give street and number)

Pickersgill Retirement Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214-46-7563

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 14 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

615 Chestnut Ave.

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Business Owner

16b. Kind of Business/Industry

Hairdresser

17. Father's Name (First, Middle, Last)

Wales Birckhead

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Wilson

19a. Informant's Name/Relationship (Type, Print)

Mr. Howard Benson/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

615 Chestnut Ave. Towson, MD. 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

4-17-99

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

K. A. B.

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. transitional cell cancer of Bladder

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

April 13, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W.A. Riley / G.B.M.C. 6701 N. Charles St Balto. md 21204

31. Date filed (Month, Day, Year)

APR 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

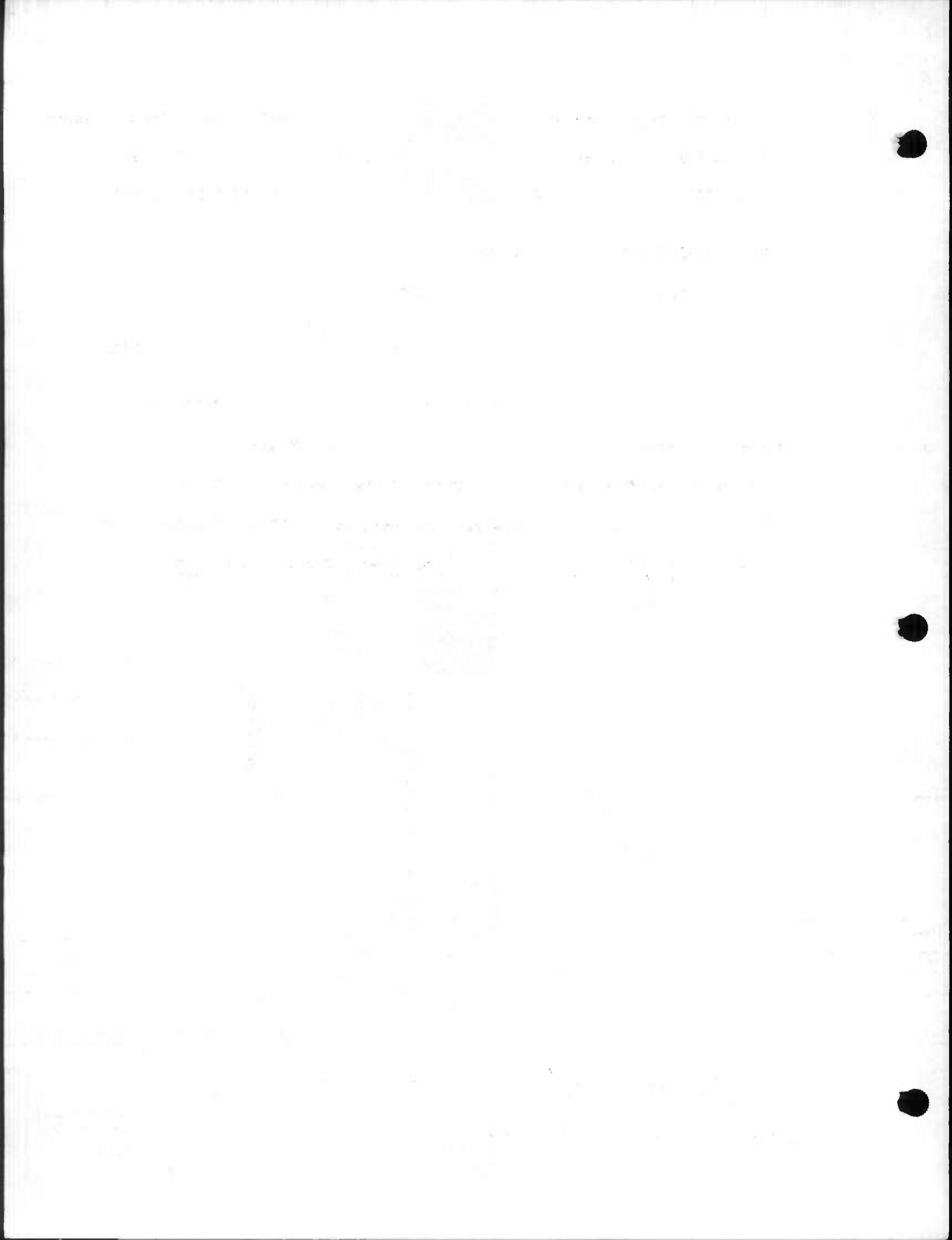
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12493

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEO R. BAHUR

2. Date of Death  
Month Day Year  
April 14, 1999

3. Time of Death  
3:40 a.m.

4a. Facility Name (If not institution, give street and number)

613 Horn Beam Road

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

213-28-7211

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 28, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

613 Horn Beam Road

10f. Zip Code

21040

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1952-56

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Crane Operator

16b. Kind of Business/Industry

Steel Company

17. Father's Name (First, Middle, Last)

Arthur Bahur

18. Mother's Name (First, Middle, Maiden Surname)

Stella Murska

19a. Informant's Name/Relationship (Type, Print)

Patricia S. Bahur (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

613 Horn Beam Road, Edgewood, MD. 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem.

Date

4/17/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD. 21014

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Prostate Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

H34022

29d. Date signed (Month, Day, Year)

April 15 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PETER LOPESTE PO 1308 Business Center Way Edgewood MD

31. Date filed (Month, Day, Year)

APR 15 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 12494

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VINCENT S BANKS SR.

2. Date of Death

Month Day Year  
APRIL 11 1999

3. Time of Death

10:50 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-14-5264

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN 1 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CIY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3826 REISTERSTOWN ROAD

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 48/49

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SR VICE PRESIDENT

16b. Kind of Business/Industry

BANKING

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Sumama)

unknown

19a. Informant's Name/Relationship (Type, Print)

Myron Banks/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2000 N. Pulaski St, Baltimore, Maryland 21217

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GARRISON FOREST

Date

4-16-99

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA

1206 W NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

ARTERIOSCLEROTIC VASCULAR DISEASE

e. Due to (or as a consequence of):

PERIPHERAL VASCULAR DISEASE

b. Due to (or as a consequence of):

SEPSIS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy

performed?

☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☒ Yes ☐ No

25. Was case referred to medical

examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

Investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 M.D. Pathologist

29c. License number

D 28244

29d. Date signed (Month, Day, Year)

4-12-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FOWZIA TAQI, M.D., 7601 OSLER DR., TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

APR 16 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

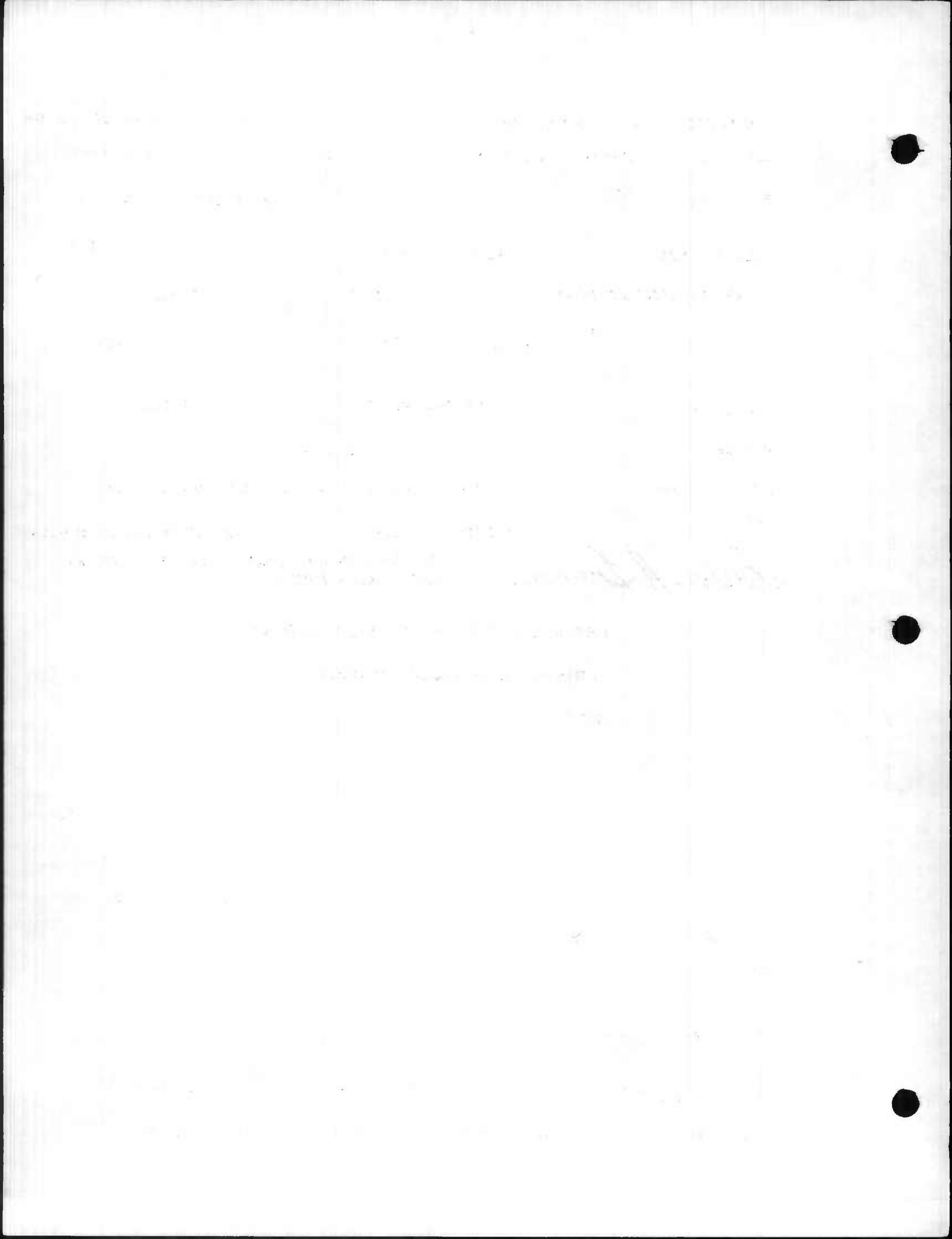
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 12495

|  |  |   |  |  |   |  |  |  |
|--|--|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Betty Ann Boecker                          |   |  |  | 2. Date of Death<br>Month Day Year<br>APRIL 15 1999 |  | 3. Time of Death<br>12:20 AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Saint Agnes Hospital |   |  |  | 4b. City, Town, or Location of Death<br>Baltimore   |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-34-1685   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>62 Yrs.  | If Under 1 Year<br>Months Days                      | 8. Date of Birth (Month, Day, Year)<br>June 26, 1936   |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |
|  | Usual Residence of Decedent  |   |  |  |   |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>Baltimore   |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br>3010 Lorena Ave.   |  |   |  | 10f. Zip Code<br>21230   |   | 10g. Citizen of What Country?<br>United States   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10   |  |   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Bank Teller  |   | 16b. Kind of Business/Industry<br>Banking  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Schwarz   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Catherine Schleicher  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>George C. Boecker, Jr. / Spouse  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3010 Lorena Ave. Baltimore, Maryland 21230  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Glen Haven Cemetery   |  | Date<br>4/19/99  |   | 20c. Location - City or Town, State<br>Glen Burnie Maryland  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>Ambrose Funeral Home of Lansdowne 21227<br>2719 Hammonds Ferry Rd. Lansdowne, Maryland   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Small cell lung cancer<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br>16 Months  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |  |   |  |  |   | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br> Ambrose Hauk, MD  |  |   |  | 29c. License number<br>D 46704   |   | 29d. Date signed (Month, Day, Year)<br>APRIL 15, 1999  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>MUTOMBO KANKONDE, ST AGNES HOSPITAL BLT MD   |  |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 16 1999   |  | 32. Registrar's Signature<br>   |  |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #18 PER F.H. G770 4-20-99 WR.

## Certificate of Death

Reg. No. 99 12496

|  |   |   |  |  |  |  |  |  |  |
|--|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EMILY BAUMGART</b>                               |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 15 1999</b> |  | 3. Time of Death<br><b>7:10 AM</b>                         |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>                          |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215 16 7558</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 6, 1920</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                     |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>                         |  | 10c. City, Town or Location<br><b>Pasadena</b>             |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>8430 Church Road</b>  |  | 10f. Zip Code<br><b>21122</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Investigator</b>  |  | 16b. Kind of Business/Industry<br><b>Motor Vehicles Adm.</b>   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Cleveland Anderson</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>KATIE ANNA HANSEL (not available)</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John Baumgart / husband</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8430 Church Road Pasadena, Maryland 21122</b>  |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  | Date<br><b>4/17/99</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Anna Brammowski</i>  |   |   |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC NON-SMALL CELL CARCINOMA 4 months</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   | Approximate Interval Between Onset and Death  |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
|  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |   | 29b. Signature and title of certifier<br><b>Qing Tang-Oxley MD</b>  |  |  |  |  |  |  |  |
|  |   | 29c. License number<br><b>P12136</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL, 15 1999</b>   |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>QING TANG-OXLEY, MD 3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225</b>  |   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 16 1999</b>  |   | 32. Registrar's Signature<br><i>Anna B. Sparks</i>  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6 APR 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 17 per F.H G-700 4/16/99 reb

## Certificate of Death

Reg. No.

99 12497

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Natalie Brown

2. Date of Death

April 11, 1999

3. Time of Death

7:43 AM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-24-6046

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 13, 1914

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6706 Everall Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Nursing Industry

17. Father's Name (First, Middle, Last)

HENRY  
Louis Edward Simkat

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Sharon Johnston (Daughter in law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Gyro Drive Baltimore, Maryland 21220

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. April 12, 1999

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Deborah Bessie Chappack

22. Name and Address of Facility

Lassahn Funeral Home, Inc.

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE CARDIOMYOPATHY 3 YR

Due to (or as a consequence of):

b. HYPERTENSIVE CARDIOVASCULAR DISEASE 20 YR

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nathan Rosenblum

29c. License number

D23319

29d. Date signed (Month, Day, Year)

APRIL 11 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATHAN ROSENBLUM 7600 ASLER DRIVE TOWSON MD 21204

31. Date filed (Month, Day, Year)

APR 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Brown, Emma

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12498

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE WASHINGTON BUTLER

2. Date of Death

Month Day Year  
APRIL 12, 1999

3. Time of Death

9:53PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

220 09 8239

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 22, 1919

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4104 THE ALAMEDA

10f. Zip Code

21218

10g. Citizen of What Country?

U.S. OF A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WAREHOUSEMAN

16b. Kind of Business/Industry

CHEMICAL COMPANY

17. Father's Name (First, Middle, Last)

MANSON BROCK, SR.

18. Mother's Name (First, Middle, Maiden Surname)

HENRIETTA TINDALL

19a. Informant's Name/Relationship (Type, Print)

BERNADETTE FRANCISCO (Daughter) 4104 THE ALAMEDA BALTO., MD. 21218

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY 4/17/99

Date

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 21215-6393  
4517 PARK HEIGHTS AVE. BALTO., MD.

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. VENTRICULAR Tachycardia  
Due to (or as a consequence of):b. Bowel obstruction  
Due to (or as a consequence of):c. Parkinson's Disease  
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Paget's disease  
Benign Prostate Hypertrophy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mohammed Ahmed MD

29c. License number

D44796

29d. Date signed (Month, Day, Year)

4-13-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMMED AHMED MD

9512 HARTFORD ROAD, BALTIMORE MD 21234

31. Date filed (Month, Day, Year)

APR 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

NAME: Butler, George W.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 12499

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR

BROOKS

2. Date of Death

Month

Day

Year

APRIL

11

1999

3. Time of Death

6:58PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212 18 8376

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 8, 1911

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5355 DENMORE AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S. OF A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 8/24/42

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

n/a

College (1-4or 5+)

n/a

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

GARAGE MANAGER

16b. Kind of Business/Industry

COMMERICAL CREDIT

17. Father's Name (First, Middle, Last)

WILLIAM PAUL BROOKS, SR.

18. Mother's Name (First, Middle, Maiden Surname)

ROSA FAGAN BROOKS

19a. Informant's Name/Relationship (Type, Print)

SHEILA IRELAND (NEICE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3670 FOREST HILL RD. BALTO., MD. 21207

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VET. CEM. 4/16/99 Date

20c. Location - City or Town, State

BALTO. OWINGS MILLS, MD. Co.

21. Signature of Funeral Service Licensed

Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 21215-6393  
4517 PARK HEIGHTS AVE. BALTO., MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

e. INTRACEREBRAL HEMORRHAGE

Approximate Interval Between Onset and Death

3 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael A. Williams, MD

29c. License number

D40041

29d. Date signed (Month, Day, Year)

APRIL 11, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MICHAEL A. WILLIAMS, MD 600 N. WOLFE STREET, BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

APR 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#8 perFH G770 4/16/99 EW

## Certificate of Death

Reg. No.

99 12500

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>JOHNNIE COUNCIL</b>   |  |  |  | 2. Date of Death<br>Month <b>4</b> Day <b>14</b> Year <b>99</b>   |  | 3. Time of Death<br><b>1:39 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Bon Secour</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>246-24-4942</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>4/14/24</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>N. Carolina</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>10 N. Rock Glen Rd.</b>  |  | 10f. Zip Code<br><b>21229</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> Collega (1-4or 5+)                      |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Bar</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>George Council</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hattie Dozier</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Doris Mack</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3837 Cherry Brook Rd.</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>mt. Zion Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Lansdowne, MD.</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>General March</b>  |  |  |  | 22. Name and Address of Facility<br><b>Gary P. March Funeral Home P.A.<br/>270 Fredrickson Pass, Balto., Md. 21229</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b><br>Due to (or as a consequence of):<br><b>Chronic Renal failure</b><br>Due to (or as a consequence of):<br><b>3 days</b><br>Due to (or as a consequence of):<br><b>3 yrs</b>                      |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Peripheral Vascular disease</b><br><b>Hypertension</b>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
|   | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br><b>Baskaran</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D 21649</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 14, 1999</b>  |  |   |  |
|   | 30. Name and address of person who completed causa of death (Item 23e) (Type, Print)<br><b>SAMBANDAR BASKARAN, 3455 Wilkens Ave. Baltimore, MD 21229</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 16 1999</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><b>B. Sparks</b>  |  |  |  | 33. State Registrar<br><b>APR 16 1999</b>   |  |   |  |
|   | 34. State Registrar<br><b>APR 16 1999</b>  |  |  |  | 35. State Registrar<br><b>APR 16 1999</b>   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

